WebTHAL

Computerized clinical record for thalassemia

User's manual

WebTHAL project

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Hardware and software requirements

To use the WebTHAL computerized clinical record, you simply need a computer provided with web browser[1]

As for web browsers, the correct operation of the We*bTHAL* program has been checked with "Internet Explorer" 4.0 and 5.0 and Netscape 4.x. The tested operating systems are Windows 95/98, Windows NT, Linux RedHat 6.x/7.x and Solaris 2.x.

Access to the program

We*bTHAL* can be used only through web browser; therefore, to have access to the program, start the browser by clicking its icon.

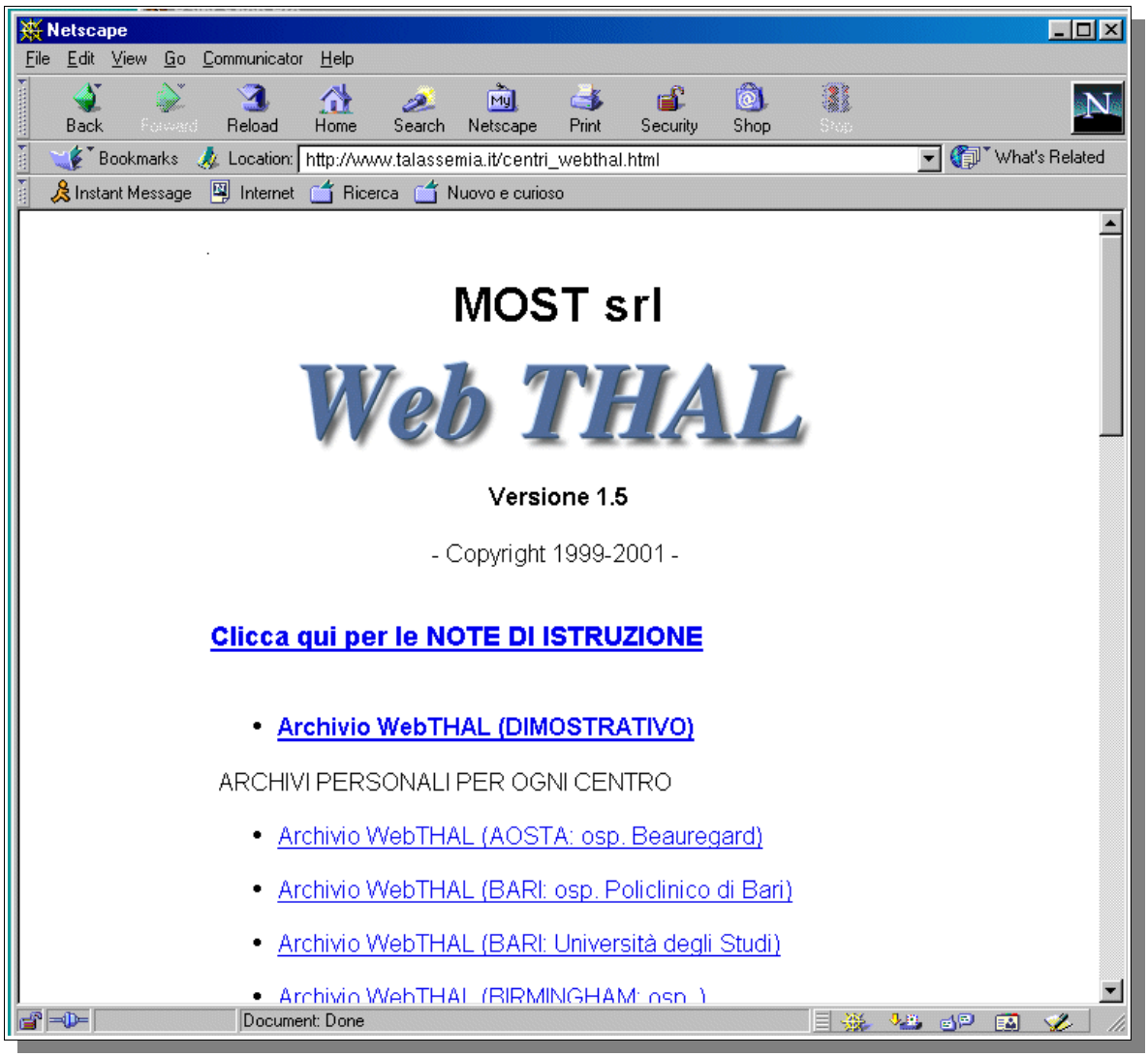
Enter the web address of We*bTHAL* national web site in the relevant space:

From the main page of the site, go to the WebTHAL centres' section:

http://www.thalassemia.it/centri_webthal.html

[1] Web Browser is the word used to identify a program for navigation through the pages of the Internet web sites.

A list of pointers will be displayed for the centres that are using W*ebTHAL*,choose the file applicable to your centre and click the link.


Netscape
File Edit View Go Communicator Help
Back Forward Reload Home Search Netscape Print Security Shop Stop
Bookmarks Location: http://www.talassemia.it/centri_webthal.html What's Related
Instant Message Internet Ricerca Nuovo e curioso
MOST srl
Web THAL
Versione 1.5
- Copyright 1999-2001 -
Clicca qui per le NOTE DI ISTRUZIONE
Archivio WebTHAL (DIMOSTRATIVO)
ARCHIVI PERSONALI PER OGNI CENTRO
Archivio WebTHAL (AOSTA: osp. Beauregard)
Archivio WebTHAL (BARI: osp. Policlinico di Bari)
Archivio WebTHAL (BARI: Università degli Studi)
Document: Done

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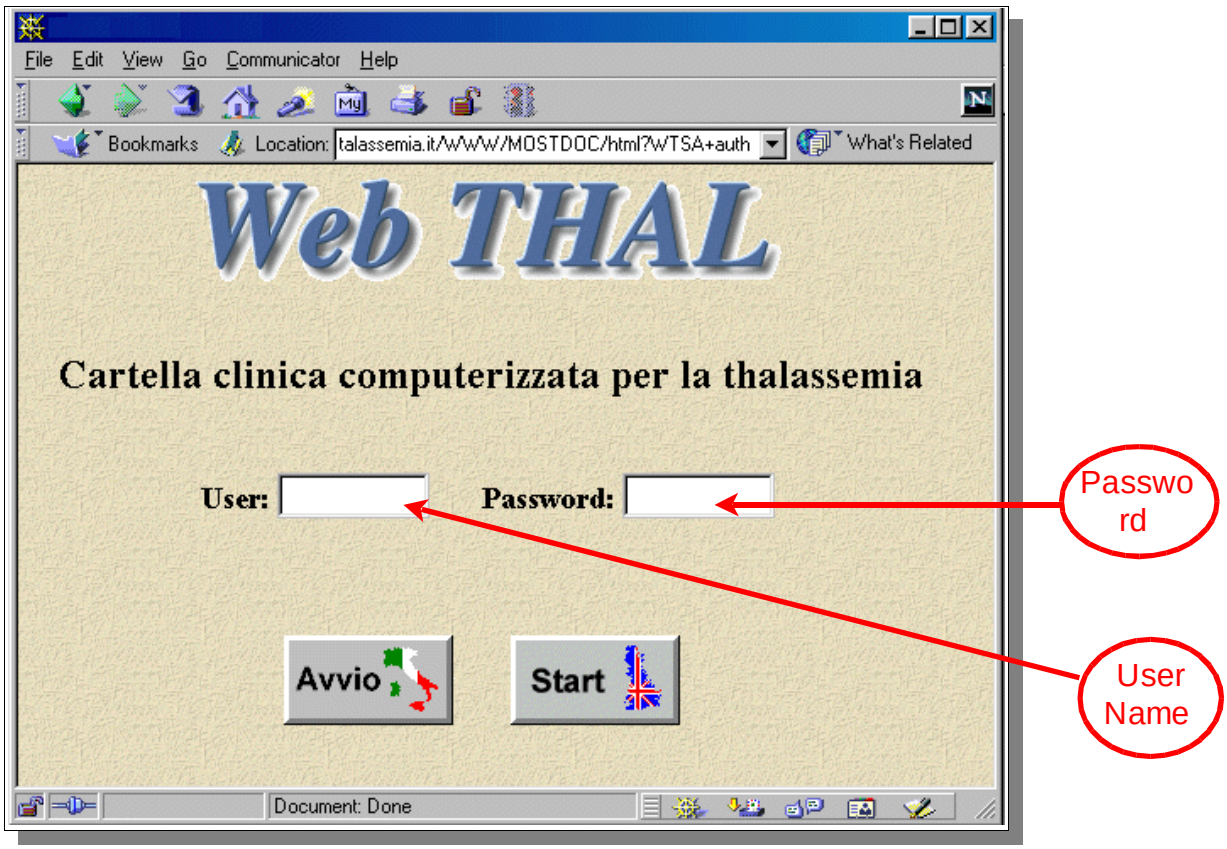
Note: The users that have a local W*ebTHAL* server in their hospital must enter the web address of their server in the "location" field, instead of the national server's address (e.g. the Turin centre must enter http://cab2.pediatria.unito.it, the Genoa centre http://webthal.galliera.it)

Running the program

After selecting the link for your centre, the user's authentication mask will be displayed.

Enter your user name and password. Be careful with the difference between small and capital letters.

If you don't remember your password, contact the software house, that will re−enable access to the program with a new password.



After entering your user name and password, press "Avvio" to run the program in Italian or "Start" to choose the English version.

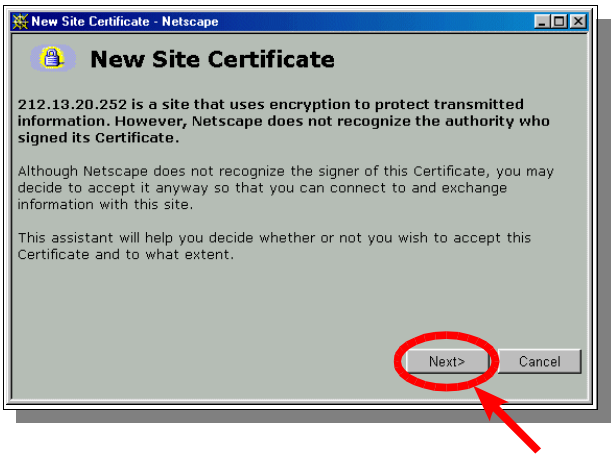
Protected connection

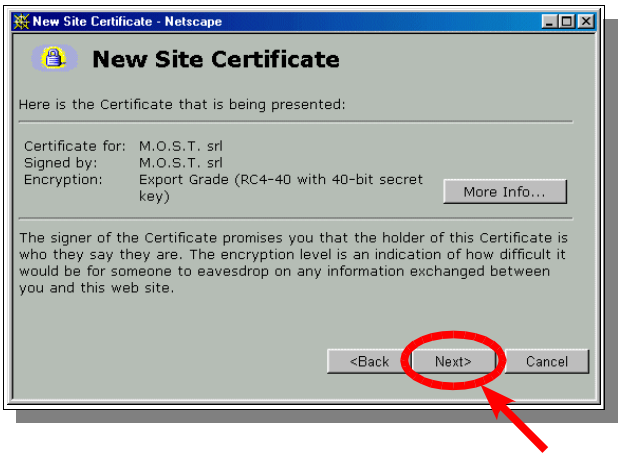
Connection to W*ebTHAL* is protected, i.e. communication on the Internet is not transmitted through legible data, but is encrypted.

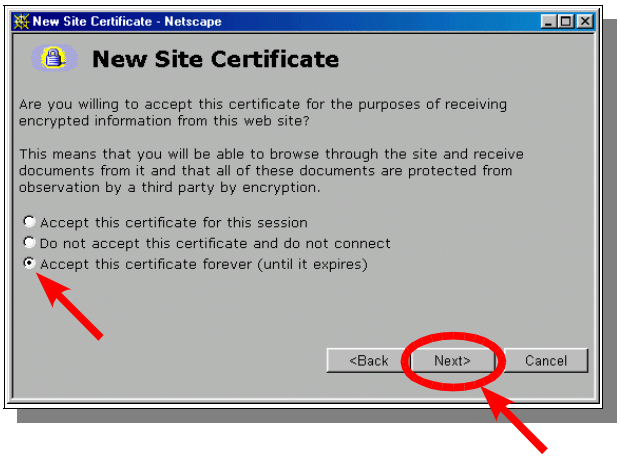
The communications protocol allowed by web browsers and servers is known as SSL

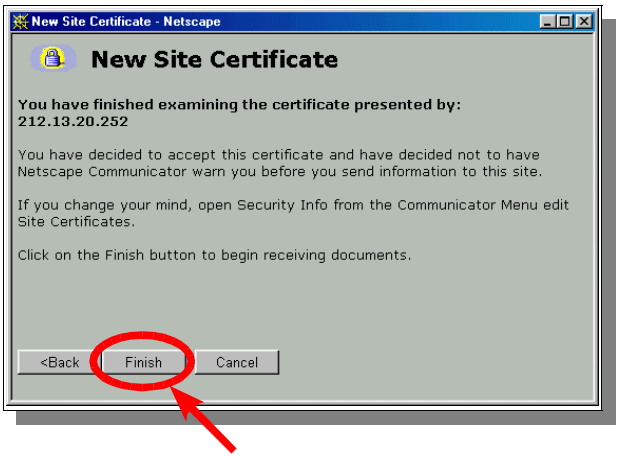
(Secure Socket Layer).The security level is the same as the one used by web sites involved in financial transactions.

When the web browser connects to a "*safe"* server, the respective credentials are exchanged for security purposes; then, on your first connection, the following enable screens will be displayed.


New Site Certificate - Netscape
New Site Certificate
212.13.20.252 is a site that uses encryption to protect transmitted information. However, Netscape does not recognize the authority who signed its Certificate.
Although Netscape does not recognize the signer of this Certificate, you may decide to accept it anyway so that you can connect to and exchange information with this site.
This assistant will help you decide whether or not you wish to accept this Certificate and to what extent.
Next>
Cancel


New Site Certificate - Netscape
New Site Certificate
Here is the Certificate that is being presented:
Certificate for: M.O.S.T. srl
Signed by: M.O.S.T. srl
Encryption: Export Grade (RC4-40 with 40-bit secret key)
More Info...
The signer of the Certificate promises you that the holder of this Certificate is who they say they are. The encryption level is an indication of how difficult it would be for someone to eavesdrop on any information exchanged between you and this web site.
<Back
Next>
Cancel

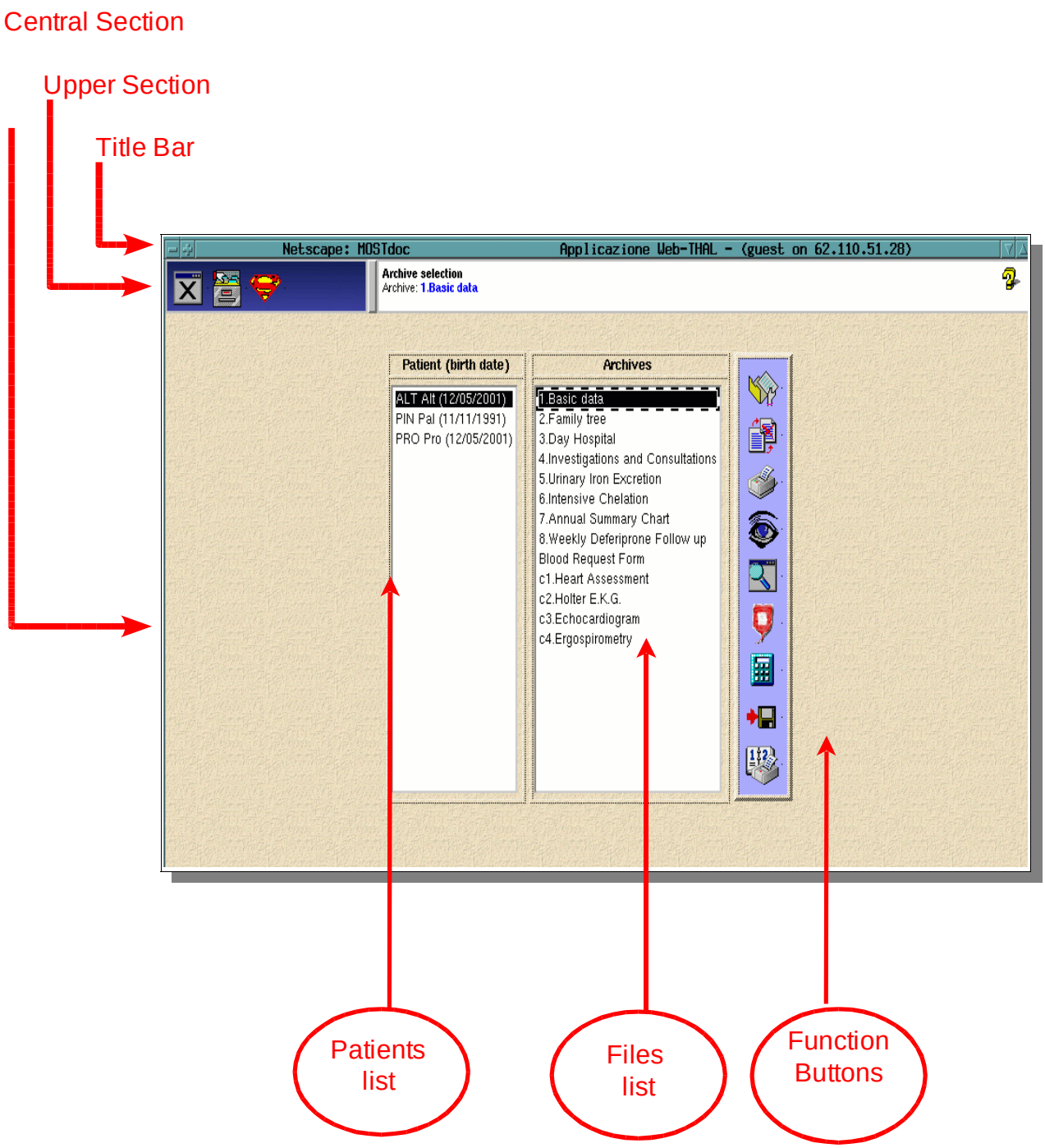

New Site Certificate - Netscape
New Site Certificate
Are you willing to accept this certificate for the purposes of receiving encrypted information from this web site?
This means that you will be able to browse through the site and receive documents from it and that all of these documents are protected from observation by a third party by encryption.
Accept this certificate for this session
Do not accept this certificate and do not connect
Accept this certificate forever (until it expires)
<Back
Next>
Cancel


New Site Certificate - Netscape
New Site Certificate
You have finished examining the certificate presented by:
212.13.20.252
You have decided to accept this certificate and have decided not to have Netscape Communicator warn you before you send information to this site.
If you change your mind, open Security Info from the Communicator Menu edit Site Certificates.
Click on the Finish button to begin receiving documents.
<Back
Finish
Cancel

To accept connection to the server in protected mode, confirm all the requests displayed.

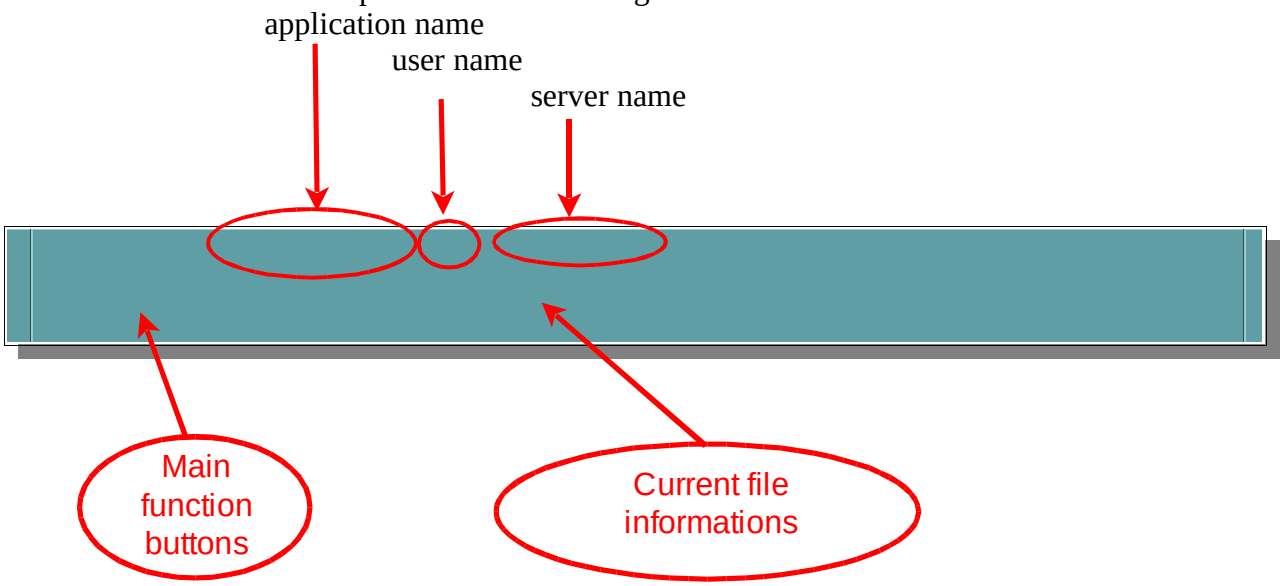
WebTHAL main page

After the authentication phase, the main page of the program is opened. The window is divided into two horizontal sections; the upper section is always available and includes the main function buttons, as well as information on the current file and function; the lower section is used by the program to present the various working phases; its content can change according to the set function.



Title bar

The window’s title bar provides the following information:



Upper section

The WebTHAL window’s upper section includes the main function buttons and information on the current file and function. This section is always visible, so that the main functions can be recalled at any time.

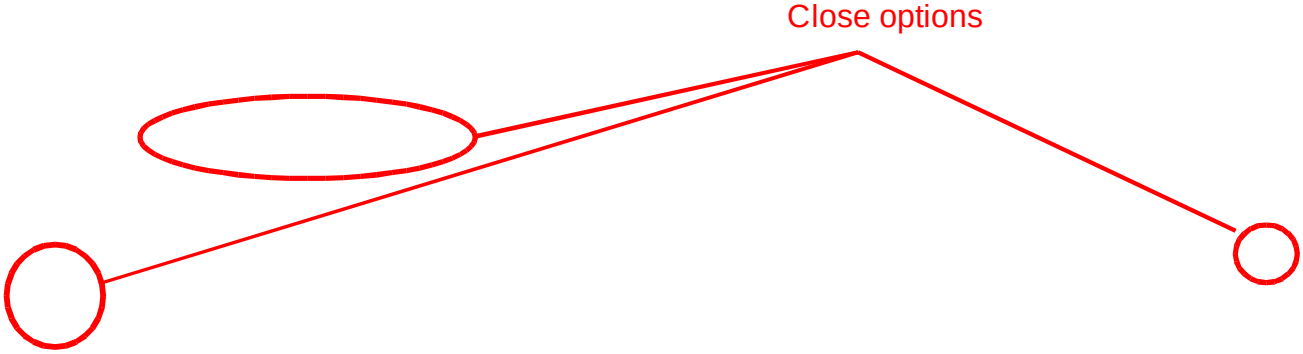
Main function buttons

Icons always visible in the upper left corner.

Closing WebTHAL

Press this button to close WebTHAL.

You can also close the browser’s window directly with ATL−F4 or by choosing the "Close" option or the "X" box in the upper left corner of the window.



Return to WebTHAL main page

This button allows you to go back to WebTHAL main page, containing the patients list, files list and function buttons, starting from any section of the program.

Changing the user password

A personal password is given to every WebTHAL user. The user may decide to modify its password at any time

When you choose this function button, you'll be requested to enter your current password and to confirm the new password twice. Once the password has been modified, all of the user's work sessions must be re−opened. The use of any login should not be personal.

The activation of a new login can be always requested to the system administrator − one for every user.

Note: The system administrator doesn't know the current password, but can re−enable access with a new password.

Information on current file

The current file (basic data file, family tree, Day Hospital, etc.) and the activated function (main menu, entering of a new record, change, search, etc.) are displayed in this area of the window.

This icon opens a web window with the online manual.

Function buttons

The WebTHAL main page displays the list of filed patients, together with their date of birth, a list of accessible files and a list of function buttons.

The file list can change according to the access levels allowed to the user.

To carry out an operation, select a patient, choose the file and click one of the function buttons.

Function buttons have the following meaning:

Entering a new record

This function is applicable to all files and is used to enter a new record in the selected file.

Record modification

When you click this button, the program shows the record list from the file of the selected patient, in decreasing chronological order. If you choose a record and confirm, you'll have access to the modification of the selected record.

Printing the clinical record

Clicking this button gives you access to the list of the record print sections, followed by print preview and print functions.

Simple search

This function button allows you to search for data in the selected file.

Advanced search

This button enables the advanced search function.

Blood delivery informations

This button allows you to enter the transfusion sac data (sac ID number and weight). These data will be automatically entered in the Day Hospital card of every patient.

Summary calculation

This function allows you to do summary calculations (means, additions, ...), starting from the data of each file, and records such results in the annual summary file. This option can be activated for a single patient or on the entire file.

Export Deferiprone data

This button allows you to activate the necessary procedure for sending data of all patients treated with chelating agent Deferiprone to the "National Deferiprone Register" (e−mail address deferiprone@medeanetwork.it).

Appointment scheduler

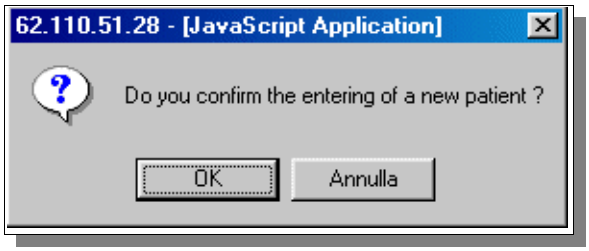
This button allows you to display and print the appointment scheduler for one or more patients.

Entering a new patient

"1. Basic data" +

To enter new data, start from basic data.

From the main page, without considering the patient over whom the pointer is positioned, select the "1.Basic data" file and click the enter button; you'll be asked to confirm.



The fields displayed concern general basic data, the main data on basic disease and the list of clinic and therapeutic programs. The data entered in this file will be automatically entered in the corresponding files, and vice−versa.

Some fields, indicated by the icon , must be filled in (Surname, Name, and Date of Birth).

Note: The fields Surname, Name, Date of Birth, Sex and Rh, once confirmed, may not be modified.

Changing basic data

Patient name + *"1. Basic Data"* +

To modify a patient's basic data, select the patient from the list, choose the basic data file and press the change function button. The program will show all current modifiable values. After effecting any change, press the icon to confirm

Note: The fields Surname, Name, Date of Birth, Sex and Rh may not be modified. To modify these fields, you must contact the software house (freephone 800.390563) or you must have a login with administration rights (super.user).

Deleting patient data

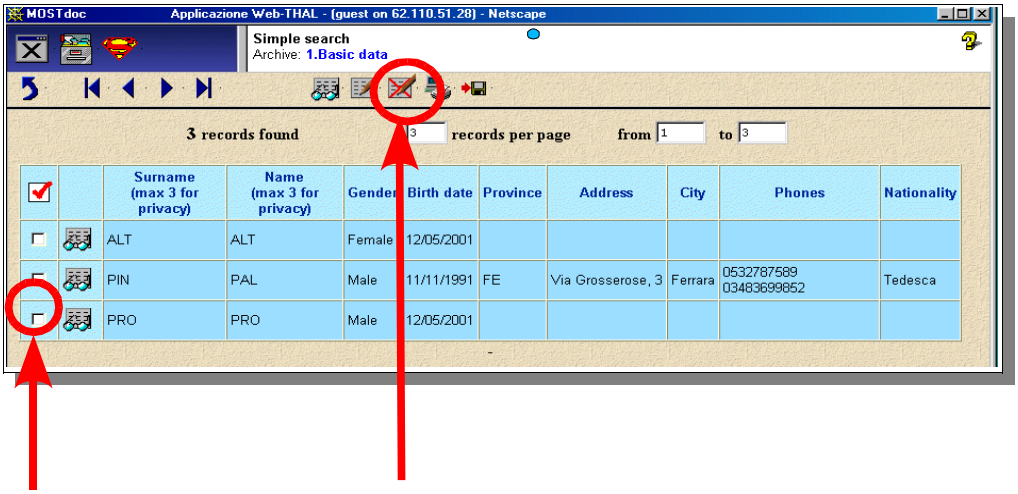
"1. Basic data" +

The deletion of all data on a patient is available only as a simple search option and not all users are enabled to do it.

To delete a patient, select the basic data file and click the simple search function button .

Set the surname/name fields of the patient to be cancelled in the search field mask and start the search; a table with the patient data will be displayed.

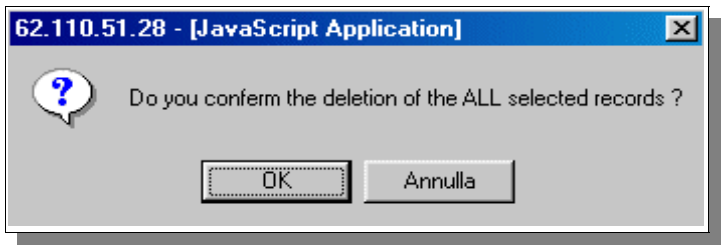
Select the record by clicking the checkbox on the left hand; then, the delete icon .



Select the record to be deleted

Delete it

Before deleting the record, you'll be asked to confirm:



If the delete icon is not present, the login being used is not enabled to proceed and you must contact the software house (freephone 800−390563).

Family tree

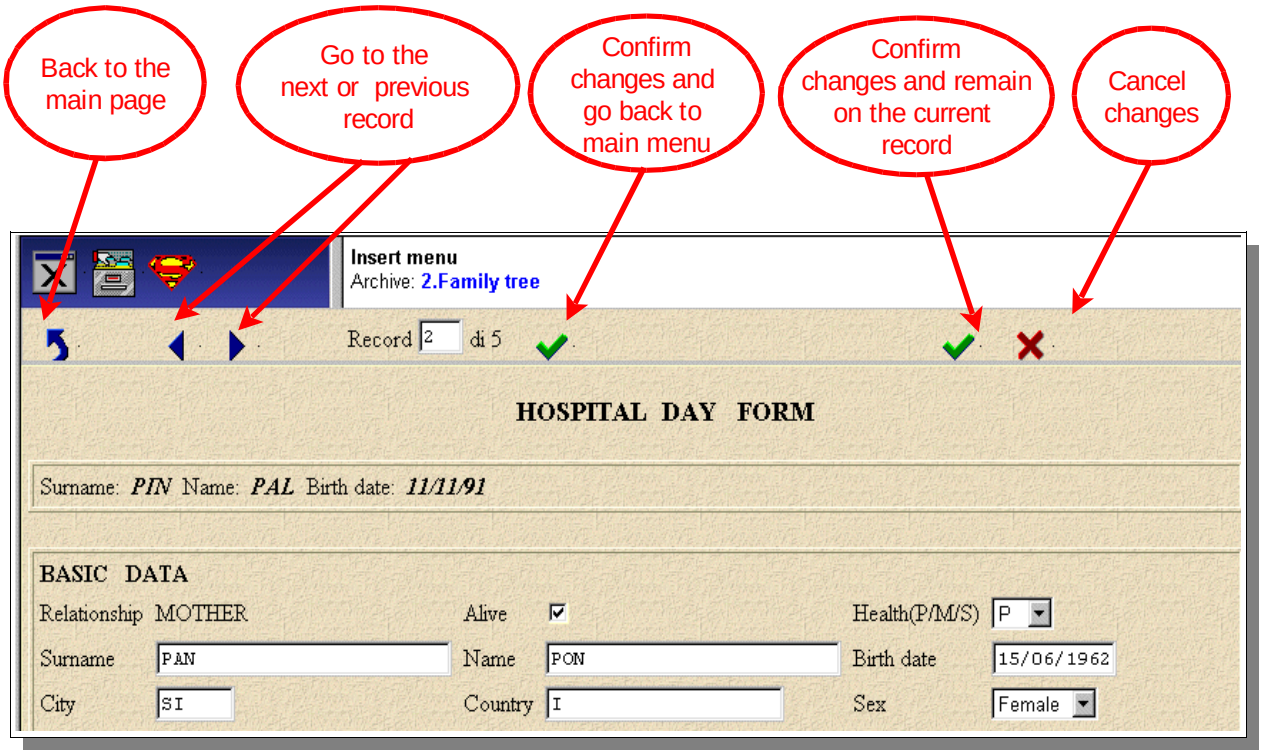
Patient Name + *"2. Family Tree "* +

WebTHAL automatically enters a record for the patient, one for his/her father and another for his/her mother in *"2. Family tree "* file. These three records are empty; therefore, you have to access the change option to enter personal data.

To do so, choose the patient from the list, select the *"2.Family tree"* file and click the change function button.

The program will display the fields to enter the data of some tests. After entering or modifying this data you can:

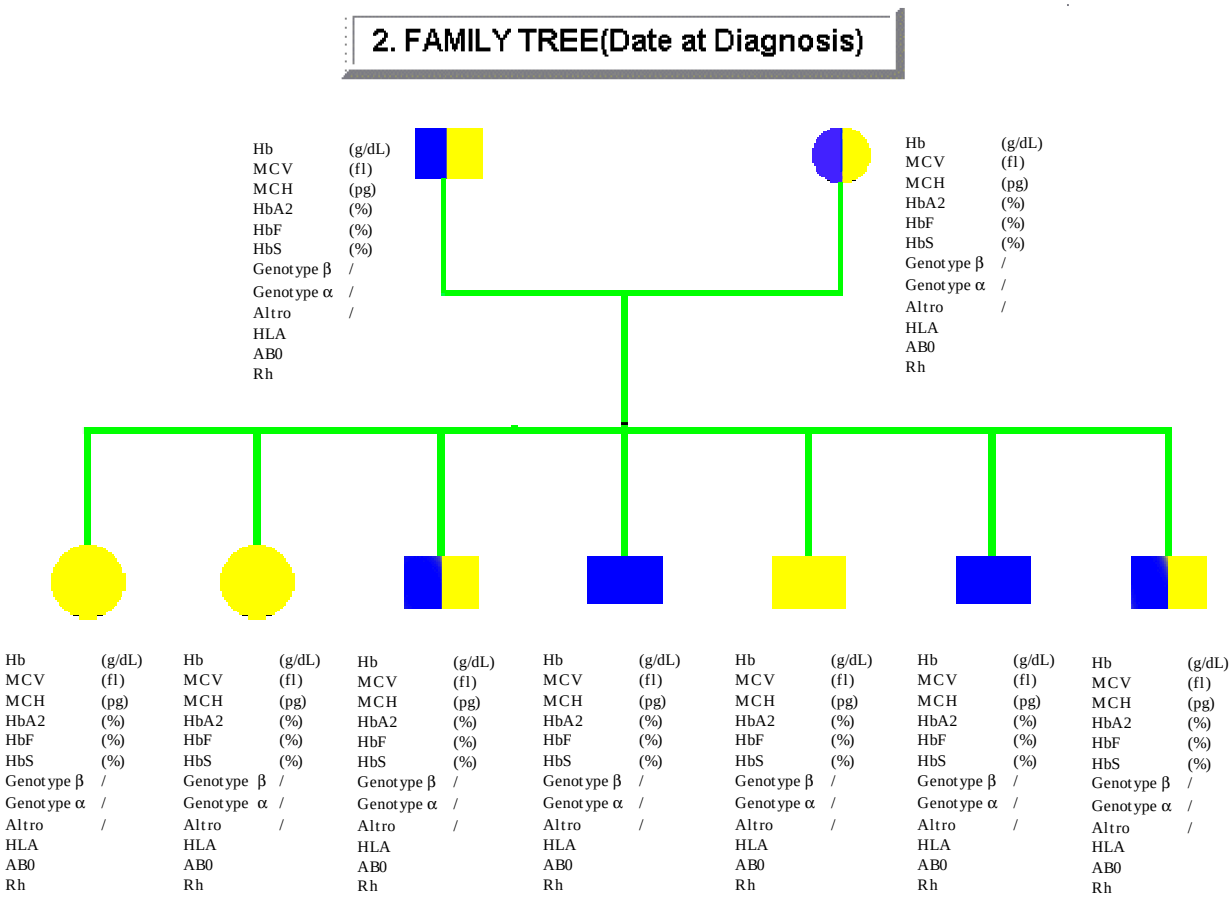
- confirm changes by clicking the icon ,
- cancel changes by clicking the icon ,
- go to previous or next data by clicking arrows and



To enter any brothers and sisters, go back to the WebTHAL main page and click the function button , select the patient from the list, choose the *"2.Family tree*" file and click the enter function button .

Patient Name + *"2. Family Tree "* +

You can enter data on the whole family, and the family tree can be shown on a print page (see print sections).

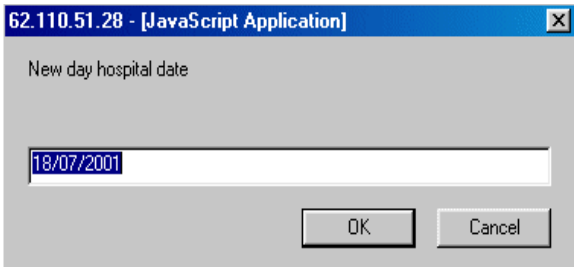


Entering a Day Hospital admission

Patient name + *"3. Day Hospital"* +

To enter a Day Hospital admission, go to WebTHAL main page, select the patient, select the *"3. Day Hospital"* file and click the enter icon.

A small window will be displayed, containing the current date.



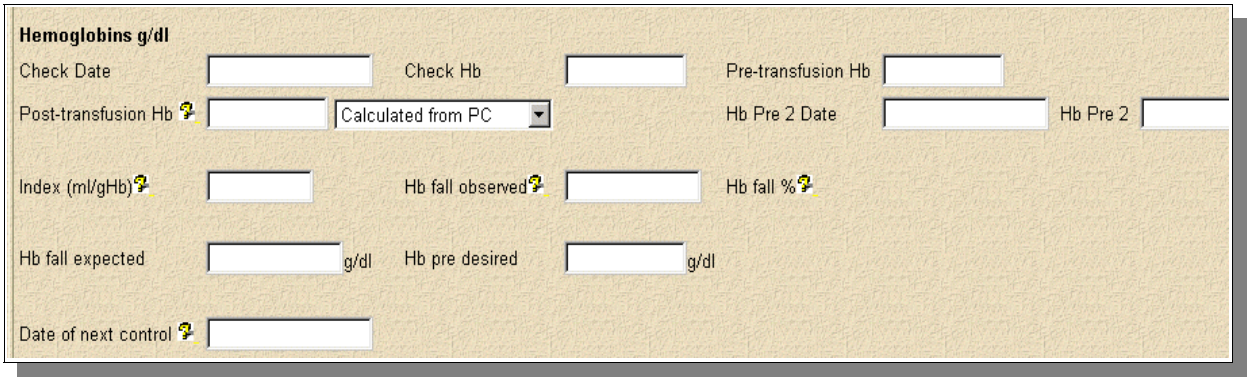
To cancel this operation, press the "Cancel" button.

If the current date is not the date of admission that you intend to enter, cancel the current date and enter the correct date. The date will be reported as date of admission to the new Day Hospital.

If the date matches an existing admission, the program will automatically positioned on the change of the corresponding admission.

At this point, the mask with all the Day Hospital fields is displayed and you can enter data.

After entering the date, the test haemoglobin, and the pre/post−transfusion haemoglobin, the program will automatically calculate the date of the next appointment. The calculated values of this and other fields can be modified by the user (*Appendix A.Formulas* on page 39 provides a detailed description of the list of calculated fields).



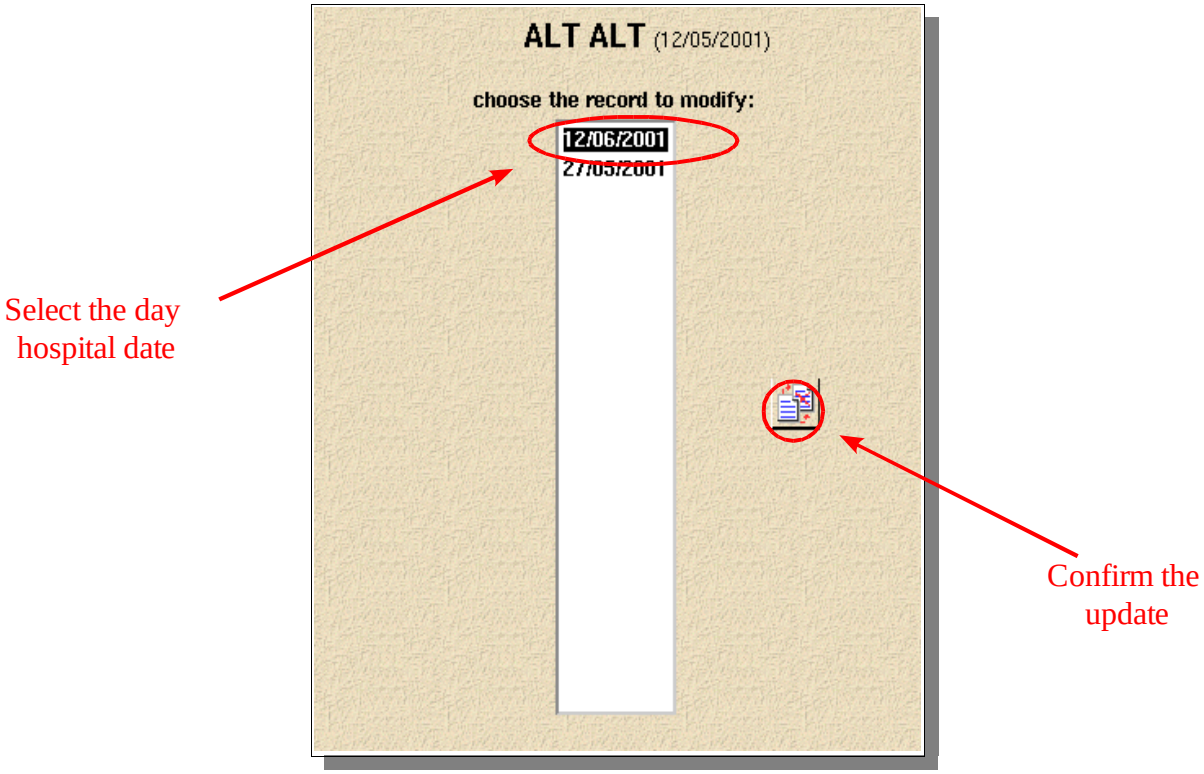
Choose OK; the program will enter the new admission in the Day Hospital file.

You can reset the fields at any time by clicking t

he icon on top. In this case, all fields are empty if a new hospitalization is being entered, or contain the original value if you are in the change mode.

After filling in the necessary data, confirm by clicking the icon on top ; the program will display the main page again.

To modify one or more fields of a Day Hospital admission, select the patient on the main page, click the change icon and select the admission date by clicking the related date. The list of fields in the Day Hospital table will be displayed again, together with the relevant values.

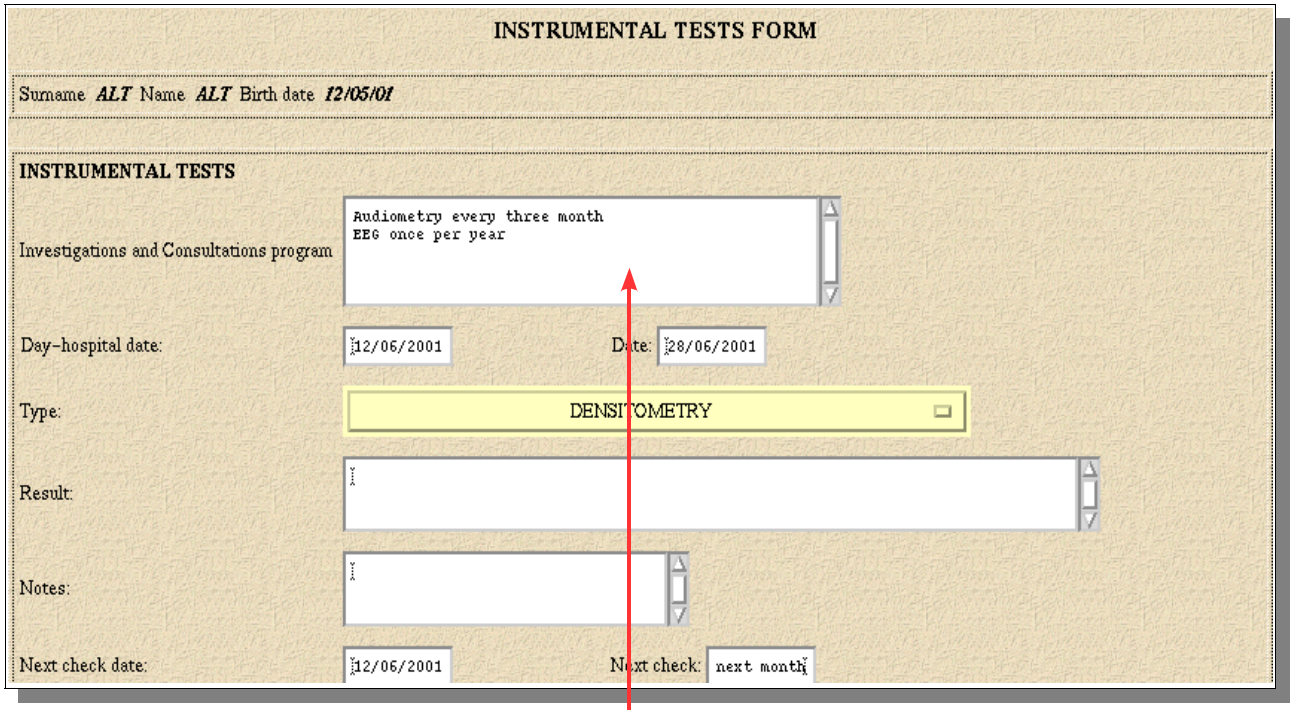


Instrumental tests file

The reports of any instrumental tests and specialist examinations, as well as any comments, can be entered in this file.

Two fields are provided to enter the next examination:

- the first is a text field where you can enter a memo (e.g. "next examination in six months")
- he second is a field date to be filled in once the next test/examination date has been confirmed.This date will be automatically reported in the discharge card and will be inserted in the appointment scheduler.

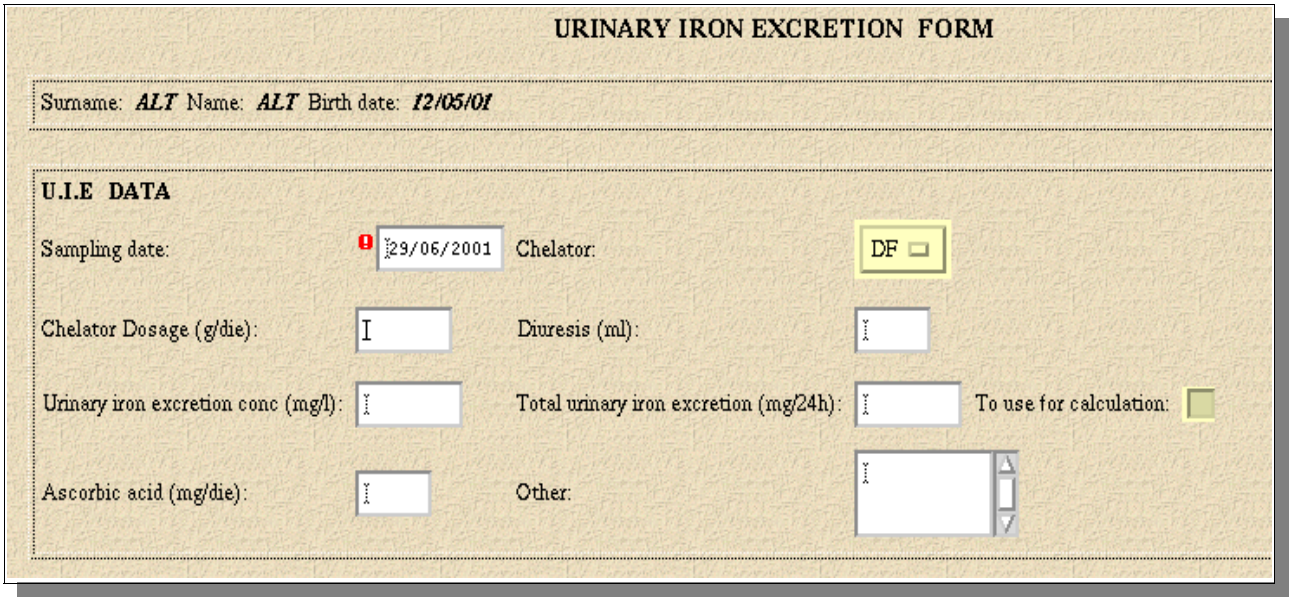


From / To the Personal data file

The *"Schedule"* can be entered and modified also in the patient's personal section, including all "schedules".

Sideruria file

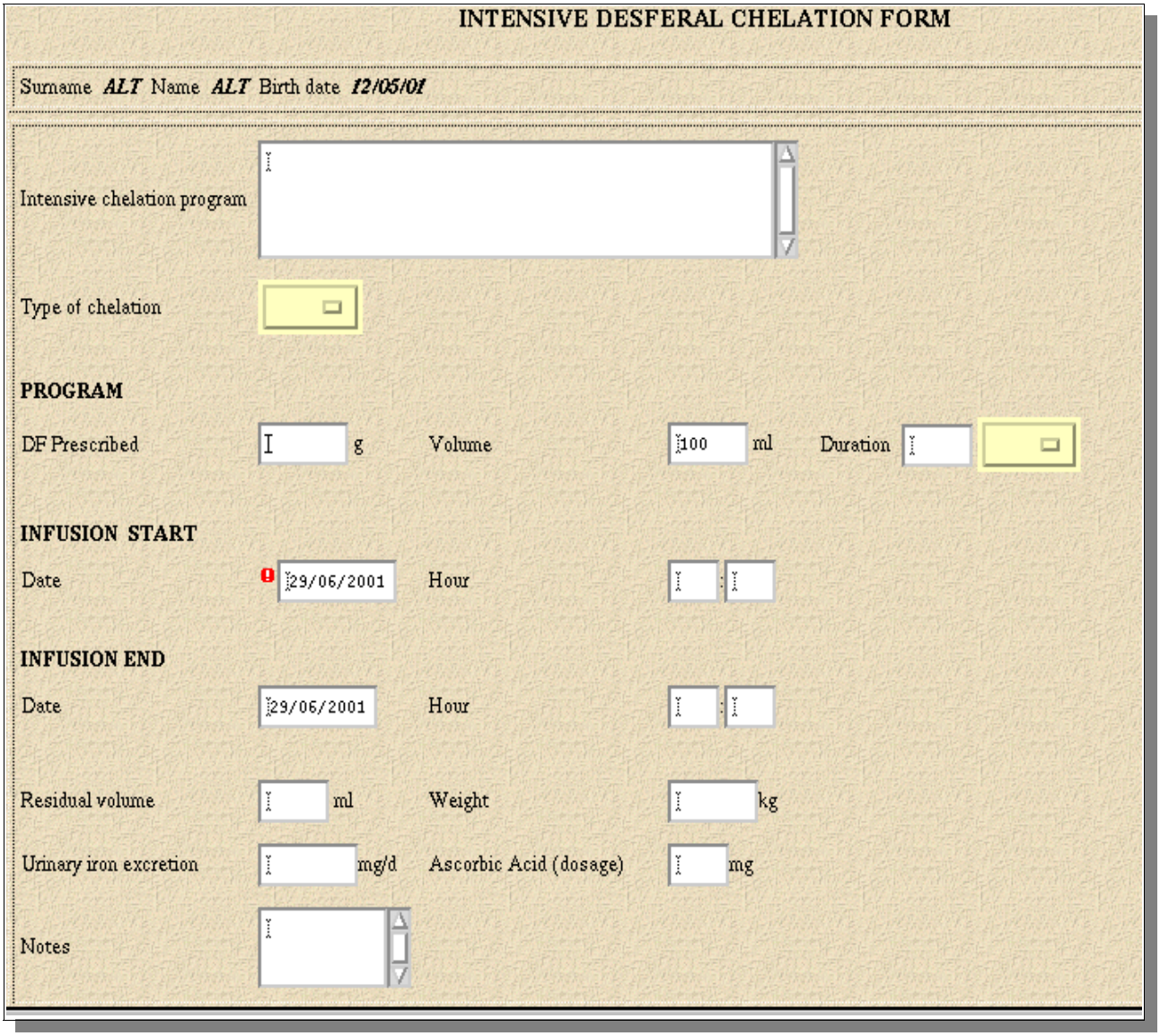
This file contains all data on the patient's sideruria. Data are ordered by date of collection, regardless of the Day Hospital admission dates.



By choosing the option *"Use for calculations"* (pre−selected automatically), WebTHAL will use this value in the summary File (calculation of the excreted iron, see formulas).

Intensive chelation file

In this file you can enter data on IV chelation. The file has been created for intensive chelation via central venous catheter, but can be used also for IV infusions from peripheral vein.



The Vitamin C and weight fields are imported automatically from the Day Hospital record nearer to the infusion date to be entered. In the presence of updated values, enter them.

During printing, the program calculates some data, such as the administered dose of desferal and the excreted iron.

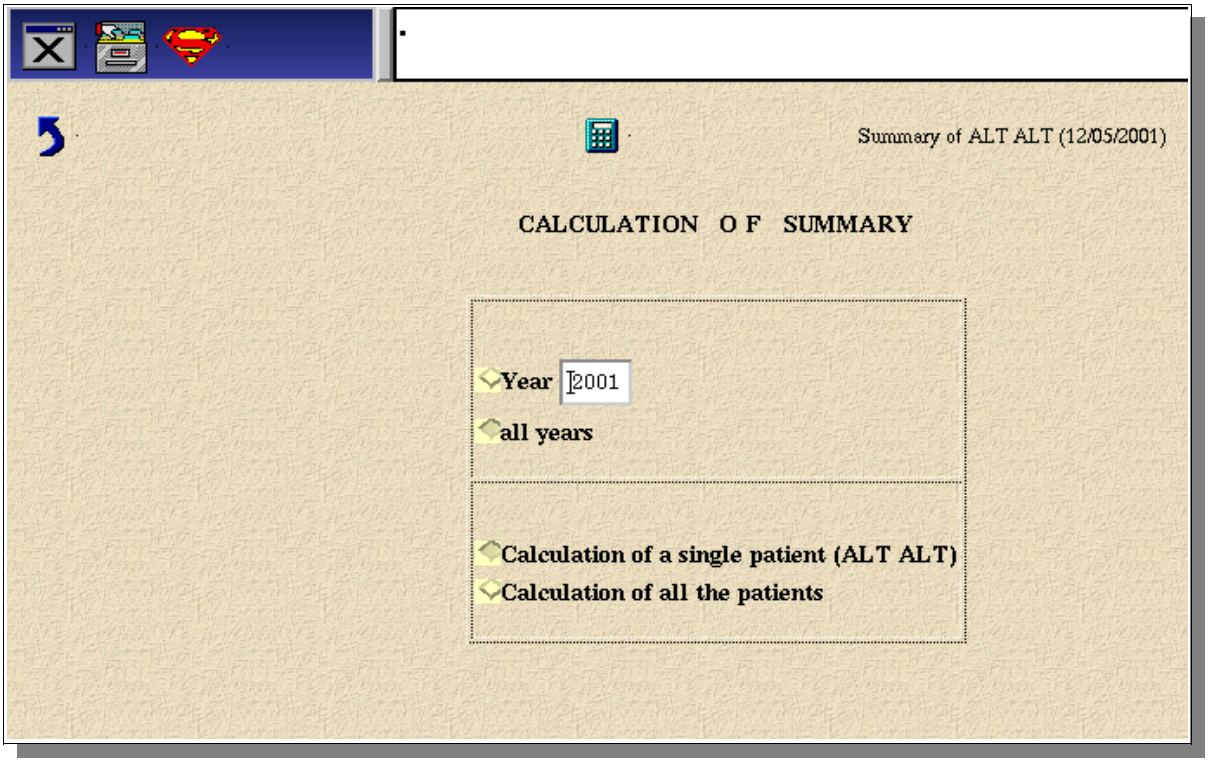
Annual summary

Patient Name + *"7. Annual Summary"* +

WebTHAL functions include calculation and arrangement of patients' annual data. The program creates a summary record for every year of life of the patient.

This function is enabled by choosing the *"Summary calculations"* function button .

Calculations can be done for the current year or for all years, for a single patient or for all patients.


Summary of ALT ALT (12/05/2001)
CALCULATION O F SUMMARY
Year 2001
all years
Calculation of a single patient (ALT ALT)
Calculation of all the patients

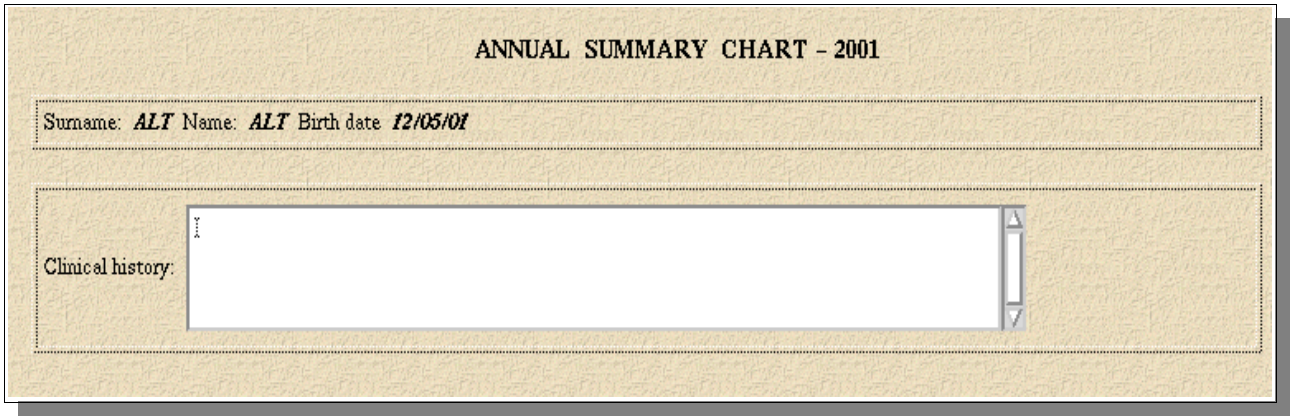
The program is automatically preset to do calculations for a single patient and for all available data *("All years* "). The operation may require a lot of time; if you want to update the data of one year, set it in the relevant box, select the related check and press the *"Summary calculations"* button.

If you want to update the summary file for all patients, choose the year to be updated and select the check relating to the *"Calculation for the record of all patients ".*

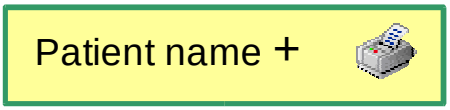
We recommend that you launch the calculation for *"all years"* for *"all patients"* in well−determined conditions, since this operation can take several hours.

In the summary card, the only part to be entered is the clinical history.

Select the patient’s name on the main page, select the "annual summary" file and click the change function button.



Printing



To access the print menu, go to the WebTHAL main page, choose the patient whose record is to be printed and click the function button .

The print menu allows you to choose the record sections to be printed. To select or deselect each section, click the checkbox near every section. To select or deselect the printing of all sections, click the symbol .

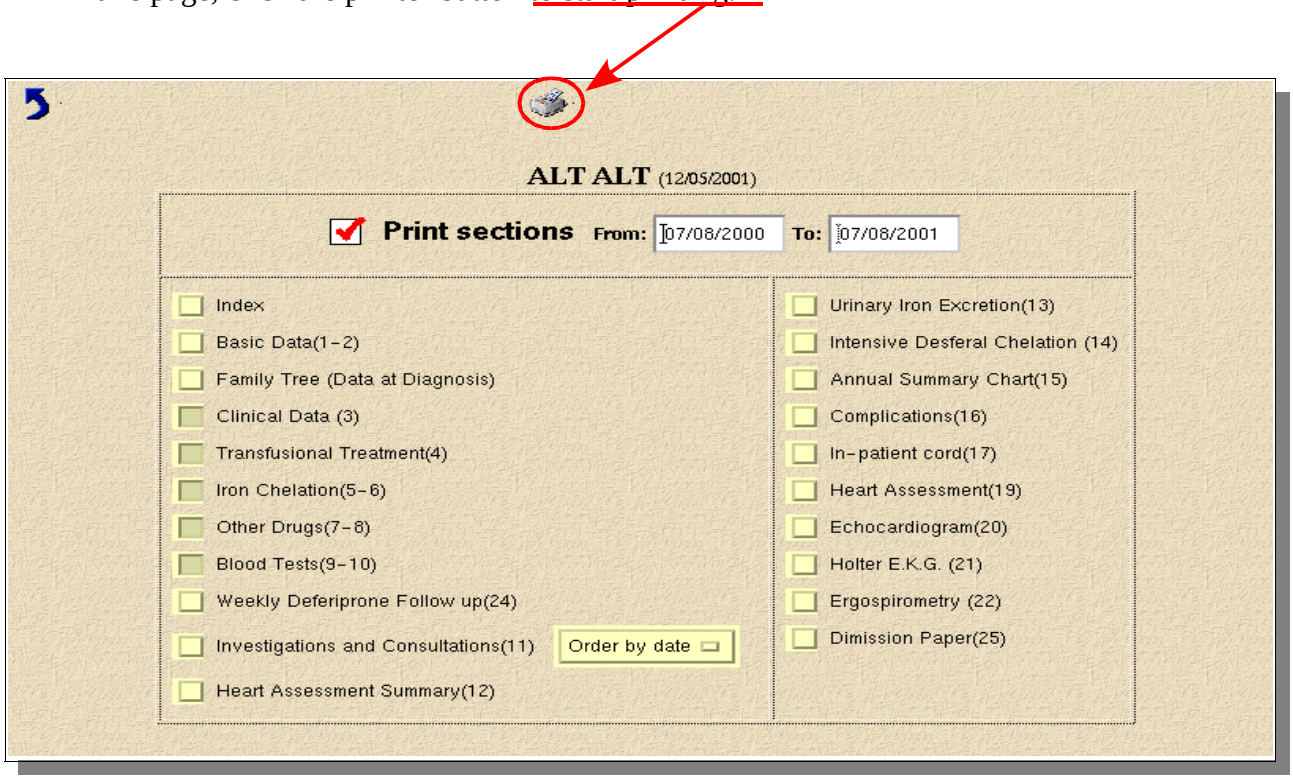
In this program, the most frequently used sections are pre−selected automatically; you can choose to accept the pre−selection or to modify it.

The preset dates allow printing of the events occurred during the last year (the couple of dates that identify the period can be modified as necessary).

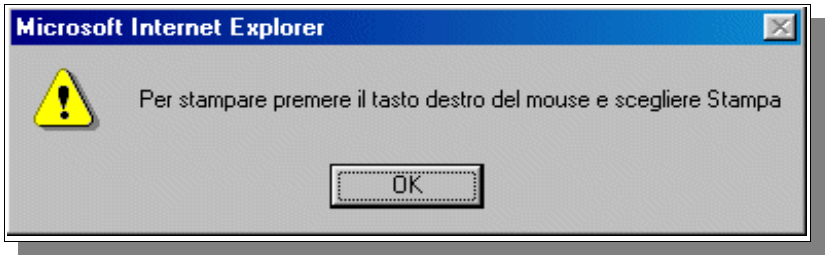
As to the *instrumental tests* section, you can choose to print it in chronological order or according to the examination type.

After selecting the sections to be printed, click the "print preview" button.

In this page, click the printer button to start printing.

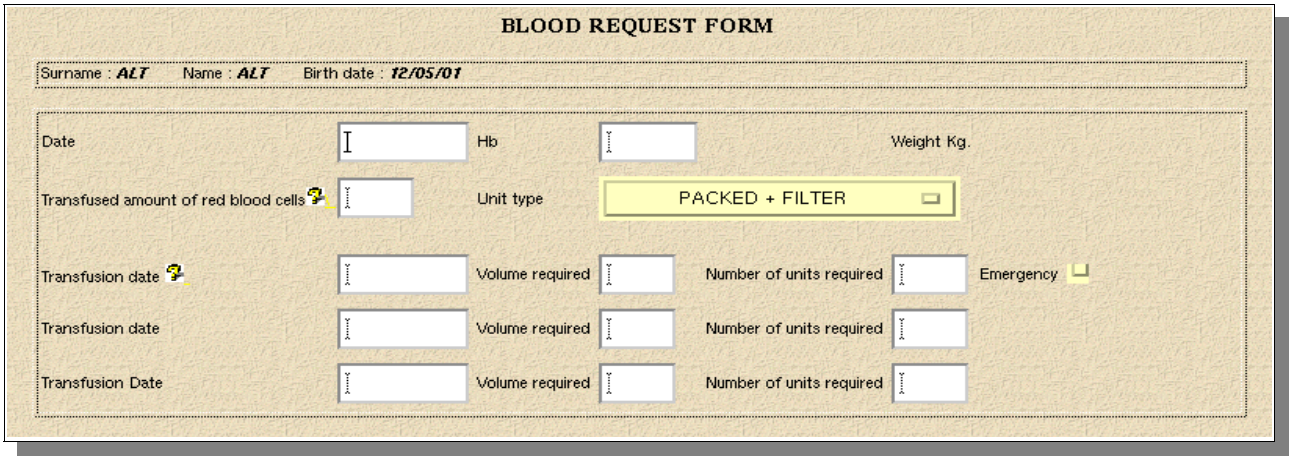


Note: when using the Explorer browser, you cannot start printing as you would do with Netscape. If you click the printer icon, the following message will be displayed:



Requesting a transfusion

The data relating to any request for transfusion for a single patient is entered in this field. The program calculates and displays 3 data: total amount of requested erythrocytes, real loss from last transfusion and transfusion date. Of course the calculated data can be modified.
The type of unit is automatically reported from the last Day Hospital.I



After filling out the mask, click the icon , the print previews for the request will appear; click the button again to print the request.
If you simply want to store data without printing the request form, click the button .

Note: A few data in the request for transfusion, such as personal data, blood group, and phenotype are automatically taken from the patient's personal data file

To modify a request for transfusion, select the patient, select the transfusion request file and click the "change" function button.

MEDICAL CENTER Xxxxxxxx HOSPITAL

10 Eaton Street - 1000 London
Chief Doctor: Dr. Kkkkkk

Hospital Code: 01005

Ward: **CENTRO MICROCITEMIE**
Tel. +39-xx-xxxxxxxxxxxxxx

Surname: **ALT** Name: **ALT** Birth date: **12/05/01**

Diagnosis: Hb at check: **12**

Blood group: AB0: Rh: Phenothype: Done on: To be done

Patient transplanted on Donor blood group: AB0:..... Rh:.....

Indication for the transfusion: R09 = protocols of thalassemia Hypertransfusional regimen (according to UNI = Italian National Board of Unification)

TYPE OF BLOOD UNIT REQUESTED

Packed Red Blood Cells	ml	unit .....
Packed & Filtered Red Blood Cells	ml **150**	unit **1**
Packed, Filtered & Washed Red Blood Cells	ml.....	unit .....
Packed, Filtered & three-Washed Red Blood Cells	ml.....	unit .....

Past transfusions:	Yes	No	**Not known**
Past transfusional reactions:	Yes	No	**Not known**
Immunization	Yes	No	**Not known**

URGENT: **- No** Date and hour choosen for collecting **13/08/2001**

- Urgent Date and hour choosen for collecting .....

(no lower than 30' after the arrival of the sample)

I certify the correct identification of the patient and I give the test tube that I have checked. I declare that I have obtained the informed consent form as required.

Date and hour: **07/08/2001 (14:26)** Signature of the physician

.....

Ready for the delivery on..... at the hour..... Signature.....

Delivered on..... at the hour..... Signature.....

SPACE RESERVED TO THE BLOOD BANK

Type of blood delivered:

Red blood cells	Unit n.....	Blood group/Rh.....	Typing blood test:	Negative	Positive
	Unit n.....	Blood group/Rh.....	Typing blood test:	Negative	Positive
	Unit n.....	Blood group/Rh.....	Typing blood test:	Negative	Positive
	Unit n.....	Blood group/Rh.....	Typing blood test:	Negative	Positive
	Unit n.....	Blood group/Rh.....	Typing blood test:	Negative	Positive
	Unit n.....	Blood group/Rh.....	Typing blood test:	Negative	Positive
	Unit n.....	Blood group/Rh.....	Typing blood test:	Negative	Positive

Works done: - Filtration - Irradiation

Signature of physician of the Blood Bank

.....

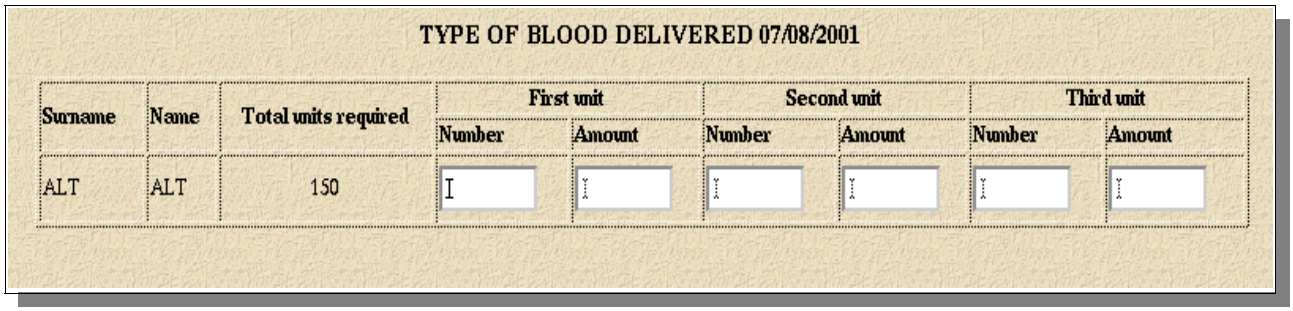
Hospital Code: 01005 - 001 / Print date 07/08/2001 WebTHAL @ / V. 0.1.6

Transfusion sac data

The data relating to the transfusion sacs received by the transfusion centre are entered in tabular form.

The specified date is the transfusion date entered in the transfusion request file.

The chart provides, for each patient treated with a transfusion on the specified date, the entering of no more than three blood units, with the relative ID number and quantity. The entered data is stored in the Day Hospital for the specified day (if the Day Hospital admission has not yet been entered, it will be created automatically).



TYPE OF BLOOD DELIVERED 07/08/2001

Surname	Name	Total units required	First unit		Second unit		Third unit	
			Number	Amount	Number	Amount	Number	Amount
ALT	ALT	150						

Exporting Deferiprone data

This function allows you to send by E−mail the data on patients treated with oral chelating therapy to the National Deferiprone Register. Vice versa, when data cannot be sent by E−mail, you can store it in a file.

The created file can be sent on a floppy/CD.

Click the button to display the data to be sent.

Confirm by clicking the ***Save on file*** button**.**

Followup Deferipron export

CODICE_L1	NATO	DATA_CONTR	HB_CONTR	NEUTRO_PERC	NEUTRO_CORR	PIASTRINE	GLOBULI_B_CORR
SIT001	28/12/1976	31/01/2000	13.2	38.90	4.57	573.0	11.77
SIT001	28/12/1976	07/02/2000	11.6	35.30	4.59	617.0	13.02
SIT001	28/12/1976	14/02/2000	10.6	35.20	5.44	690.0	15.46
SIT001	28/12/1976	21/02/2000	12.5	41.30	5.88	626.0	14.26
SIT001	28/12/1976	02/03/2000	10.7	37.90	5.01	709.0	13.23
SIT001	28/12/1976	10/03/2000	12.0	39.90	4.27	601.0	10.72
SIT001	28/12/1976	20/03/2000	10.8	35.90	3.70	649.0	10.32
SIT001	28/12/1976	27/03/2000	10.0	53.20	3.90	751.0	7.33
SIT001	28/12/1976	03/04/2000	11.8	39.90	3.90	641.0	9.79
SIT001	28/12/1976	10/04/2000	10.2	28.70	4.95	724.0	17.25
SIT001	28/12/1976	17/04/2000	10.1	47.90	4.79	785.0	10.00
SIT001	28/12/1976	26/04/2000	10.9	46.20	7.72	796.0	16.72

CHECK INFORMATION

The red cells are empty fields; if you want to fill them write L1 code's patient and his check date and go back to main menu: choose patient, l1 archive and click on update button and add absent informations

If informations are ok click on "Save as file" button and choose file name to send as attachment to follow address:

deferiprone@medeanetwork.it (click here to open the mail)

Cancel **Save as file**

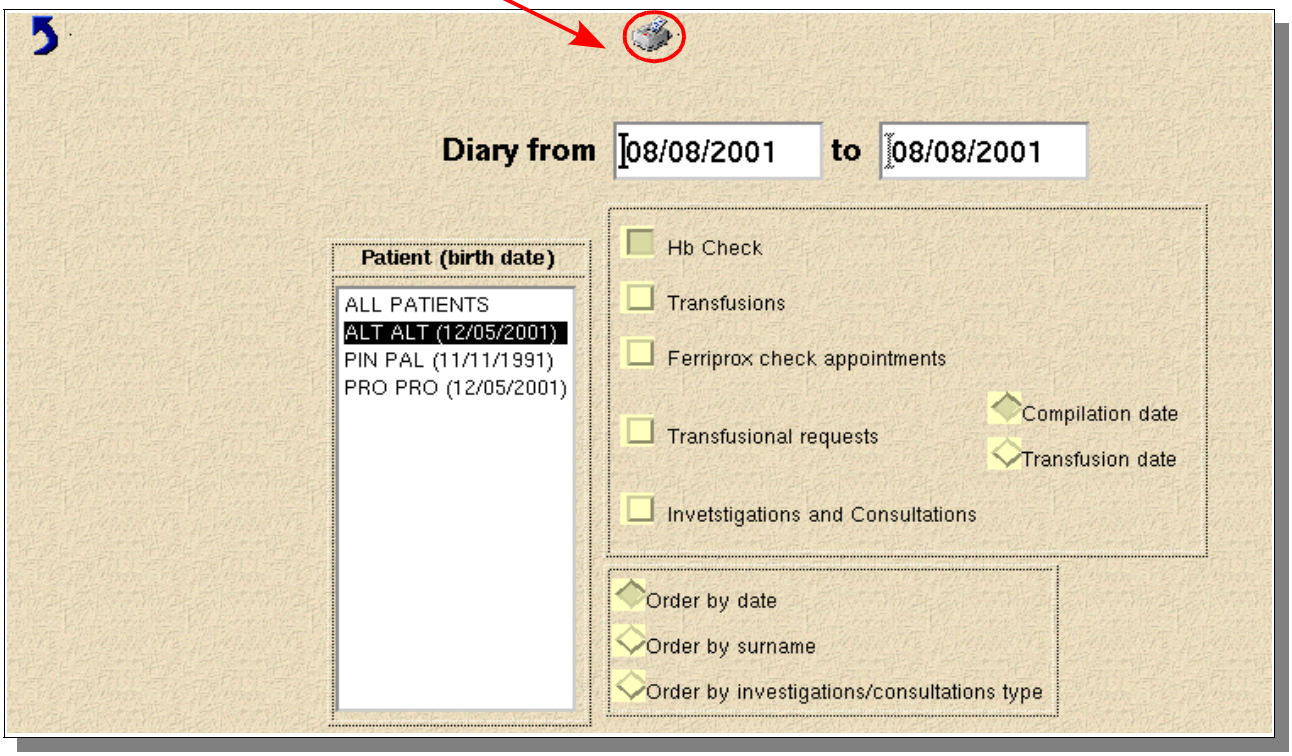
The National Register is maintained by prof. Adriana Ceci. Data must be sent to E−mail address deferiprone@medeanetwork.it

Appointment scheduler

The appointment scheduler section allows you to sum up the entered data.
The preset date corresponds to the current day; however, you can choose the period freely.
The list of appointments can refer to a single patient or all patients.
The following books are provided:

- *Hb check :* Day Hospital appointment for the checking of cross tests
- *Transfusions* : transfusion dates already included in Day Hospital
- *Requests for transfusion (filling out date*): list of requests for transfusion filled out on a certain day/period
- *Requests for transfusion (transfusion date):* list of transfusions scheduled on a certain day/period
- *Specialist examinations*: list of specialist examinations scheduled on a certain day (the date for the *examination confirmed on* field is indicated, from the specialist examinations file)
- *Ferriprox control appointments*: control appointments entered in the Deferiprone file.

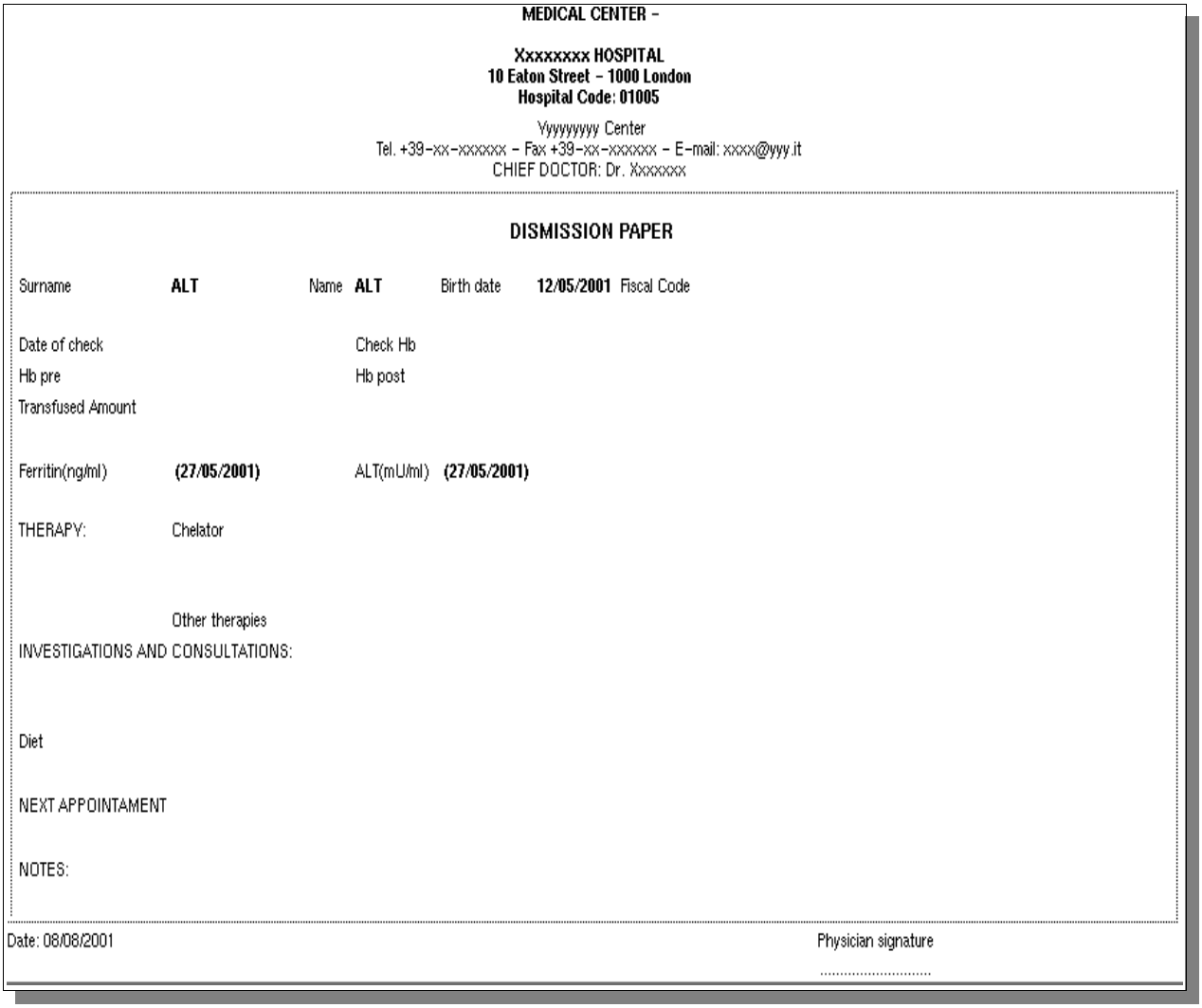
You can choose to order appointments by date, surname, test (this one only for the specialist examinations scheduler).
Click *print preview* to view the book before printing.



Discharge card

This card generates a printed report that can be delivered to the patient on discharge.

The displayed data are imported from the Day Hospital file (from the last admission or, if absent, from preceding admissions) and the tests/specialist examinations file.



MEDICAL CENTER -

Xxxxxxxx HOSPITAL
10 Eaton Street - 1000 London
Hospital Code: 01005

Yyyyyyyy Center
Tel. +39-xx-xxxxxx - Fax +39-xx-xxxxxx - E-mail: xxxx@yyy.it
CHIEF DOCTOR: Dr. Xxxxxxx

DISMISSION PAPER

Surname **ALT** Name **ALT** Birth date **12/05/2001** Fiscal Code

Date of check Check Hb
Hb pre Hb post
Transfused Amount

Ferritin(ng/ml) **(27/05/2001)** ALT(mU/ml) **(27/05/2001)**

THERAPY: Chelator

Other therapies
INVESTIGATIONS AND CONSULTATIONS:

Diet

NEXT APPOINTAMENT

NOTES:

Date: 08/08/2001 Physician signature

.....

Specialist section

WebTHAL has been conceived to provide you with a basic folder that includes essential data for a proper follow−up of thalassaemic patients. Other specialist sections will be added to this file over time.

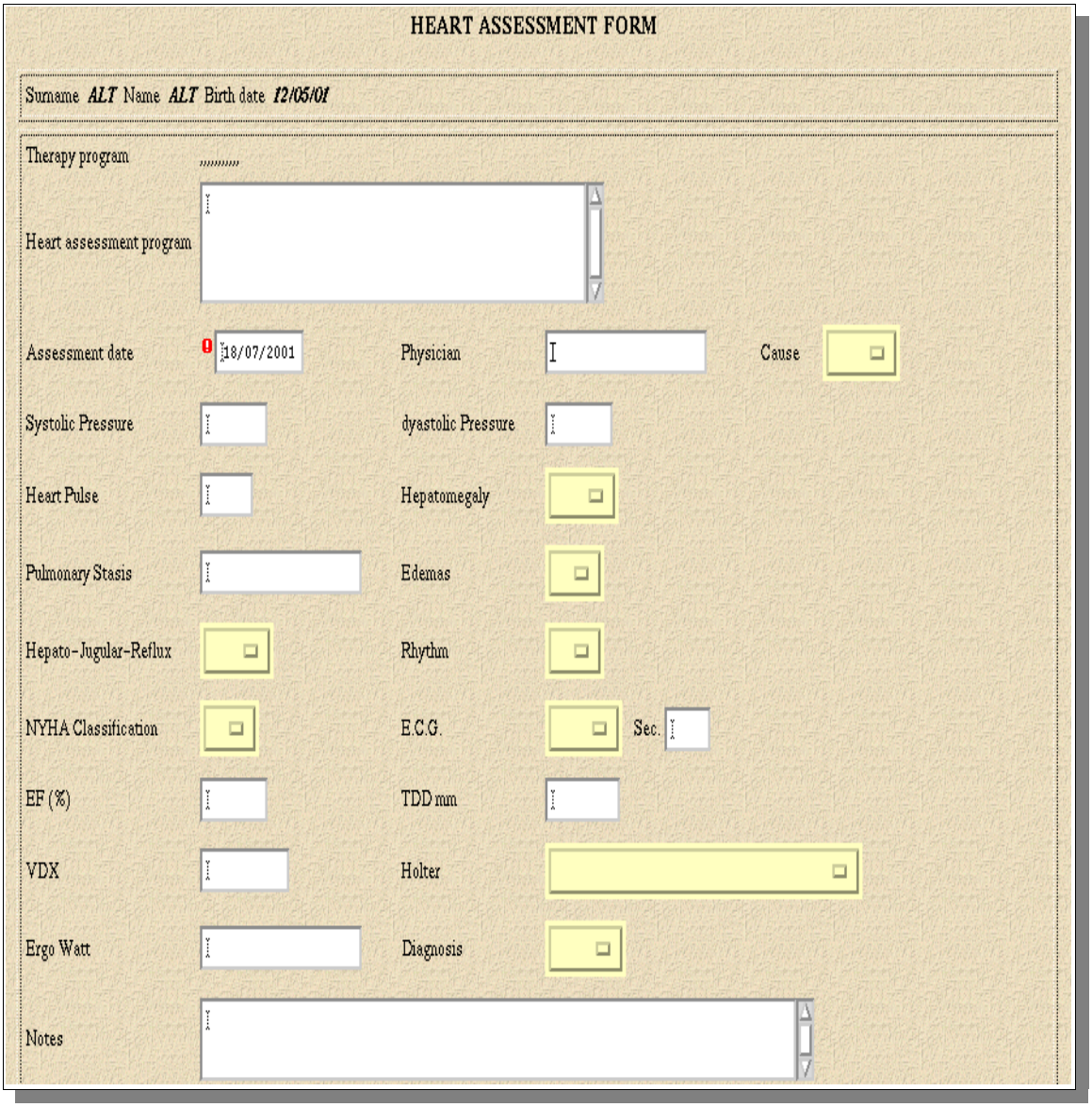
The first one is the cardiological section, consisting of four files:

1. Cardiological Card
2. Ecocardiography Card
3. Dynamic E.C.G. Card (Holter)
4. Ergospirometry card

This manual illustrates only the first card, that provides a summary of the data on this pathology.

Cardiological card

The data on the cardiological examination of the patient is entered in this file.
The displayed therapy is the one reported in the last Day Hospital of the patient.



Simple search

The program allows you to perform both simple and advanced searches.
To perform a Simple Search, proceed as follows:

- select the patient on WebTHAL main page
- Select the file to search
- Click the simple search button

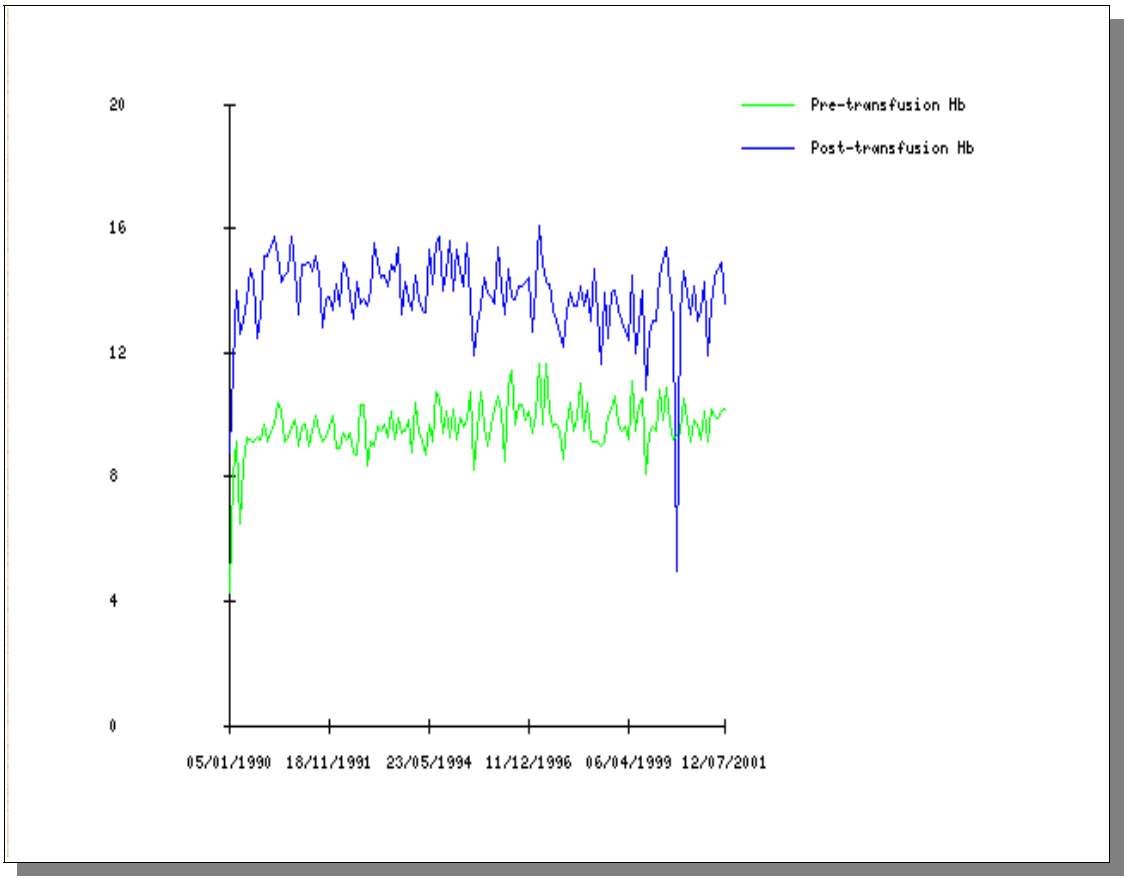
- A mask to be filled in will appear − enter:
  - the patient's name, if you want to search a single patient (for the preset Day Hospital file)
  - the search period
  - the search operators (see next paragraph)
  - the fields to be displayed with any limits
  - the result order (increasing or decreasing)

- Click the ***Search*** button (if more than 1000 matches are expected, increase this number)
- A table with the relevant data will be displayed; now the program allows you to:
  - show complete records with the button
  - modify the selected records with the button
  - cancel the selected records with the button
  - print the search results on client/server with the button
  - export the search result with the button
  - display an indicative chart with the button

The result of a search for pre/post−transfusion haemoglobin in a patient is illustrated below. The search has been performed over 10 years, and the enclosed chart shows the trend of haemoglobin values (X−axis) and time (Y−axis).

	Date in	Pre-transfusion Hb	Post-transfusion Hb
	05/01/1990	4.3	8.8
	16/01/1990	8.0	11.5
	07/02/1990	9.1	14.0
	07/03/1990	6.5	12.6
	21/03/1990	8.4	13.0

	Date in	Pre-transfusion Hb	Post-transfusion Hb
	10/04/1990	9.3	13.7
	03/05/1990	9.2	14.7
	29/05/1990	9.1	14.3
	23/06/1990	9.3	12.5
	07/07/1990	9.2	13.2



Search operators

Search operators are different for every type of data.
If the data on which the search condition is set are **text strings**, the available operators are:

- **"Include"** and **"Exclude"** that check the presence of a sub−string in the field**.**
- **=** and <> (not equal), that check equality and inequality. Be careful with the difference between capital and small letters (during a search, the same capital/small letter is considered as two distinct letters − e.g. *"mario"* is different from *"Mario*").
- > , < , >=, and **<=** that operate on the lexicographic (alphabetic) order. All capital letters precede small letters.

If the data on which the search condition is set are **numbers**, the following mathematical operators can be used: > , < , **>=, <=,** =, and <> (not equal).

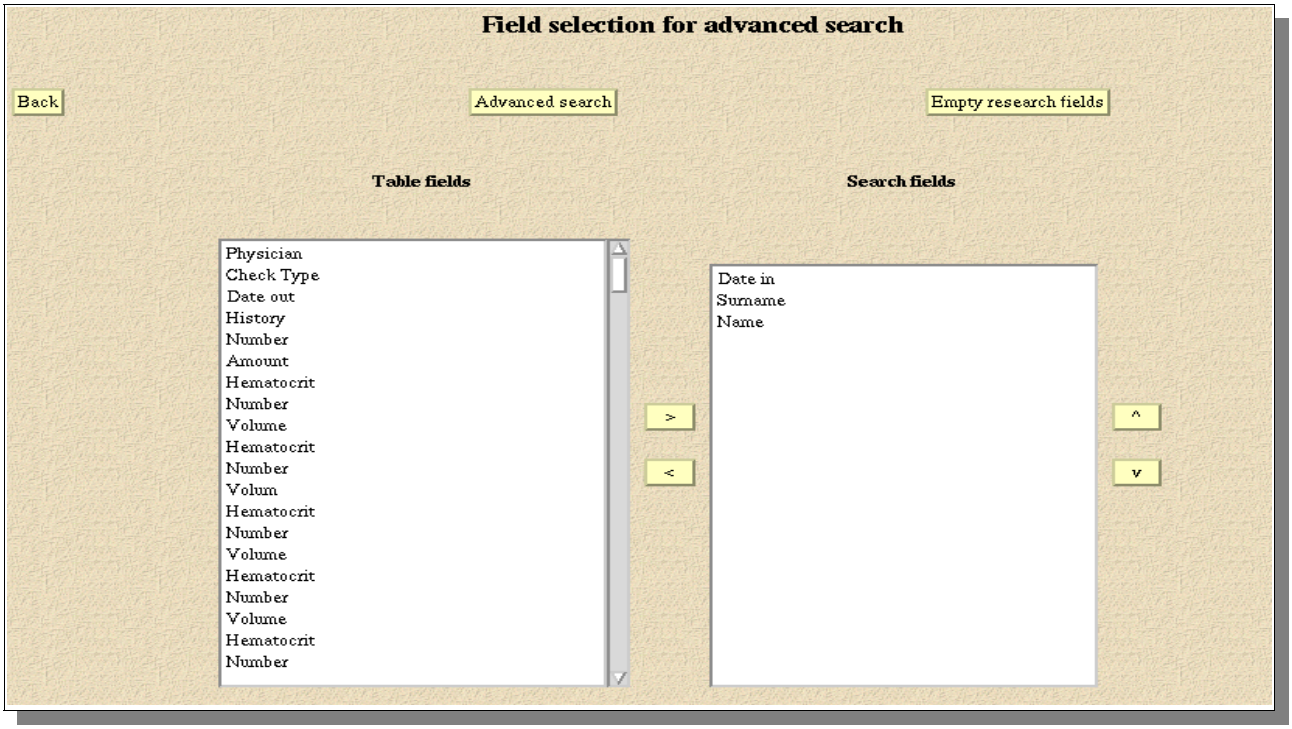
If the data on which the search condition is set are **option menus**, the available operators are only **=** and <> (not equal).

Advanced search

The advanced search is a WebTHAL function that allows you to set the search query directly. This is an alternative to simple search, for a more flexible setting of the query, that requests basic knowledge of Boolean algebra.

To access it, click the icon

Regarding the Day Hospital file, that consists of a large number of fields, the fields to search must be preset.



To select the search fields, highlight fields in the ***File fields*** list on the left, and click the > button. The Fields will be moved to the right, in the ***Fields to search*** list.

The < button moves to the left−hand list the fields highlighted in the right−hand list that you want to exclude from the search.

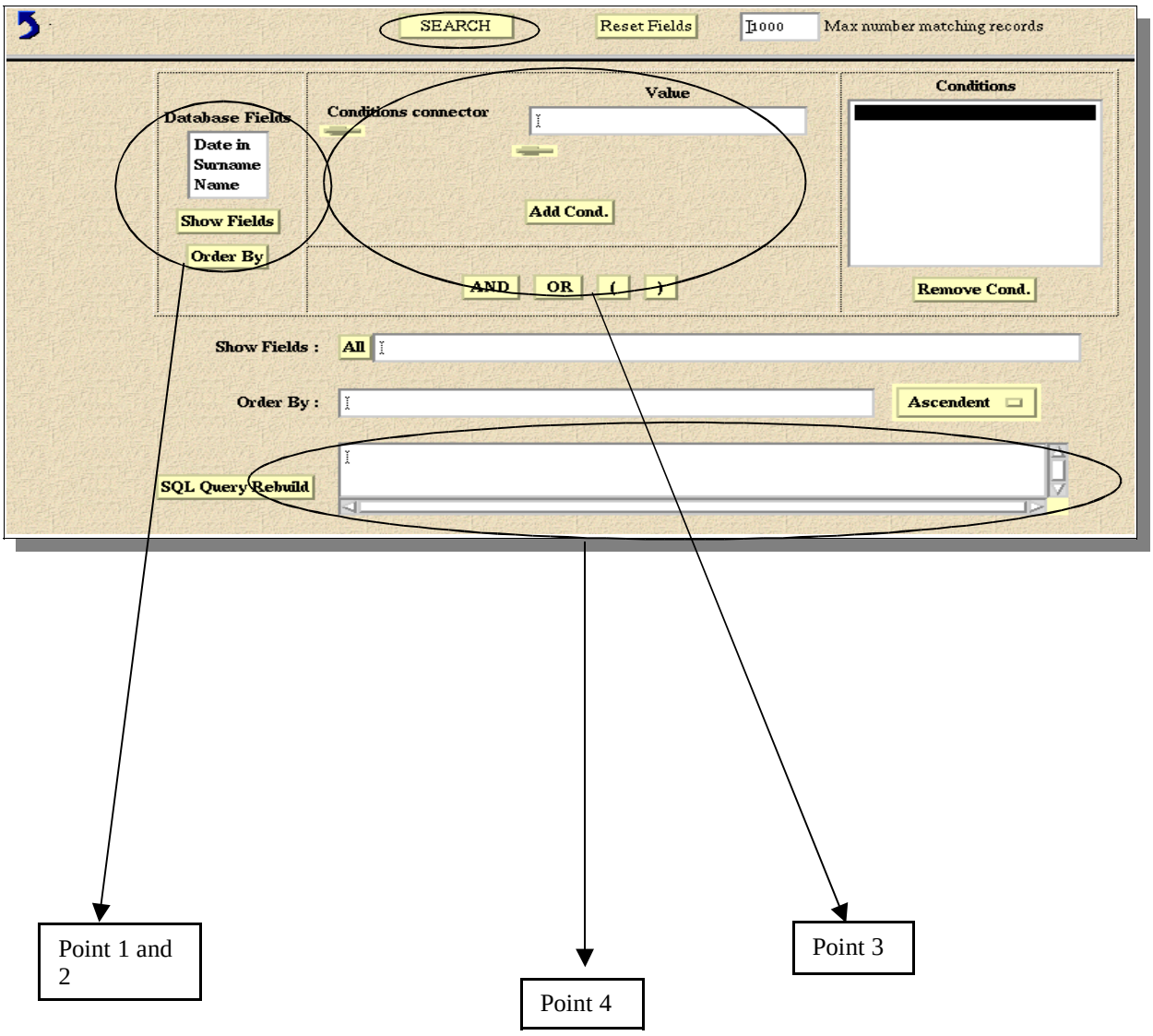
Buttons ^ and v move the field highlighted in the right−hand list up or down, by one position, in order to modify the data order in the search result.

Click the ***Advanced search*** button.

The displayed page allows you to:

1. **Choose the fields to show in the search result:**
   select the field to be added to the results of the pull−down menu that contains the list of file fields and confirm by clicking the *Display* button.
   You can also choose all the file fields (more quickly), by clicking the *"All"* button.

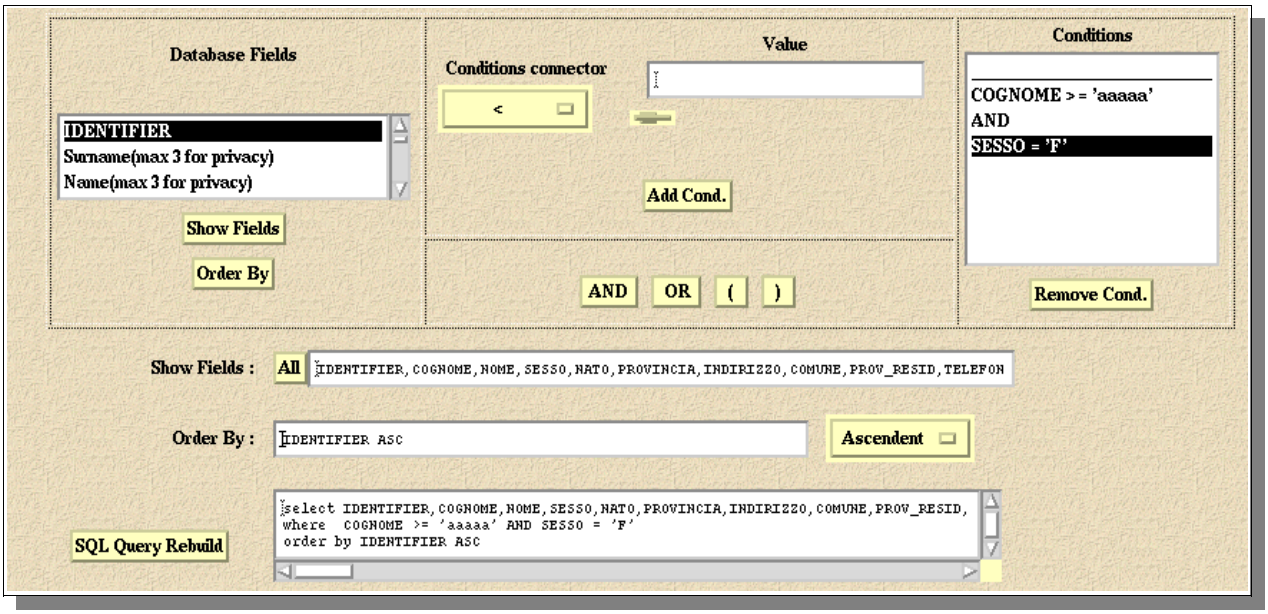
2. **Choose the result order:**
   select the order type by clicking the pull−down menu (Decreasing/increasing order); select the field on which the results from the list of file fields will be ordered and confirm by clicking the *"Order By"* button.
   You can select several fields to order results.



3. **Set the search conditions**

- Select the field on which you want to set the condition.
- Select the related operator (operators depend on the type of field involved in the conditions and are the same as those available for simple search).
- Enter the comparison value (if the field provides a group of prefixed values, a menu is displayed below the field, with the values provided for the field).
- Confirm the set condition by clicking *"Add Condition"*
  You can combine more conditions using AND and OR operators (Boolean algebra) and modify their priority with parantheses (N.B.: the AND operator takes priority over the OR operator). To use operators and paretheses, click the *AND OR and ( )* buttons.
  If, during the compilation of compound conditions, you want to remove a condition inserted by mistake, highlight it and click *Remove Condition.*
- Confirm the search setting by clicking *Query Sql.*
  The set selection is displayed in the relevant window.
  To correct the set query, you can cancel the set data going to the data entry windows and filling them or writing directly inside them, or through the automatic compilation explained above.
  *Y*ou can always remove the entire set query by clicking *"Field Reset"*.
- Start the search by clicking the *Search* button.

The figure shows an example of compound condition setting:



Examples of advanced search:

1) To obtain the list of all patients with ferritin > 1000 in alphabetical order

Set the following selection:

select COGNOME,NOME, FERRITINA from WTTO.VISTA_CARTELLE where FERRITINA > 1000 order by COGNOME ASC,NOME ASC

- **fields to be displayed** Surname Name and Ferritin
- **order** Surname (increasing) and Name (increasing)
- **condition** Ferritin > 1000

2) To obtain the list of all patients with AST > 100

select COGNOME,NOME from WTTO.VISTA_CARTELLE where AST > 100 or ALT > 100 order by cognome asc, nome asc, data_ingr asc

- **fields to be displayed** Surname Name and Ferritin
- **order** Surname (increasing), Name (increasing) and admission date
- **condition** AST > 100 or ALT > 100 (if either condition is met the hospitalization is included in the search result)

3) To obtain the list of all patients with AST > 100 and ferritin > 1500

select COGNOME,NOME,DATA_INGR from WTTO.VISTA_CARTELLE where (AST > 100 or ALT > 100) and FERRITINA > 1500 order by cognome asc, nome asc, data_ingr asc

- **fields to be displayed** Surname, Name and admission date
- **order** Surname (increasing), Name (increasing) and admission date
- **condition** AST > 100 or ALT > 100 and FERRITIN > 1500 (both one of the conditions relating to transaminase and the condition relating to ferritin must be met to have the hospitalization included in the search result)

Appendix A − Formulas

This section details all fields whose value is stored by WebTHAL through a formula.

The *"calculated"* fields are divided by file, and their numbering can be used as reference in the tables that describe the files included in Appendix B.

The field name is the one entered in the database.

The table relating to each field contains the descriptive formula (first line), the formula expressed with the database fields' names (second line) and any (optional) notes (third line).

DAY HOSPITAL FILE

1. GRAMMI_TRAS

Transfused amount pure GR = $\sum (sac\,weight * hematocrit)$
GRAMMI_TRAS= ∑ transfusion sac(P_SACCAi * Q_SACCAi)

2. INTERVALLO

Intervall = $date\,\text{in} - previous\,date\,out$
INTERVALLO= DATA_INGR − DATA_USC_PREC
NOTE: **I**f previous date out is empty or previous date out = 0 interval =0

3.HB_POST

3.1) **DFO Patient treated with a transfusion in 1 day with calculated hb_post and patient L1**

HB post = $hb\ pre + \frac{transfused\ amout\ pure\ GR}{average\ index\ last\ six\ month}$
HB_POST=HB_PRE+ (GRAMMI_TRAS / MED_FABB)
NOTE: Computed only if average index last six month is not equal to 0

3.2) **DFO Patient with hb_pre2 (transfusion in several days)**

HB post = $hb\ pre\ 2°\ day + \frac{amount\ pure\ GR\ transfused\ during\ 2°day}{intertransfusional\ index}$
HB_POST=HB_PRE2+ (GRAMMI_TRAS / FABB_INTERTRASF)
NOTE: Computed only if intertransfusional index is not equal to 0 (see 4.2 at page 40) 2° day means last transfusional day when transfusion lasts more days.

3.3) **Re−calculation for Patient L1 using the data of the last follow up L1**

HB post= $follow\ up\ hb + \left[average\ hb\ fall\ observed * (follow\ up\ date - previous\ date\,\text{in}) \right]$
HB_POST=HB_CONTR+ (MED_DECR * (DATA_CONTR − DATA_INGR_PREC))
NOTE: If (follow up date − previous date in) > 10 days a warning is shown.

4.INFUS_SET

4.1) **DFO Patient treated with a transfusion in 1 day with measured hb_post, or patient with hb_pre2, or re−calculation for patient L1, using the data of the last follow up L1**

Index = $\frac{transfused\ amount\ pure\ GR}{(hb\ post - hb\ pre)}$
INFUS_SETT = GRAMMI_TRAS / (HB_POST − HB_PRE)
NOTE: Computed only if hb_post > hb_pre

4.2) **DFO Patient with hb_pre2 (transfusion in several days)**

Intertransfusional index = $\frac{amount\ pure\ GR\ transfused\ during\ days\ previous\ hb\ pre\ 2°day}{(hb\ pre\ 2°day - hb\ pre)}$
INFUS_SETT = GRAMMI_TRAS / (HB_PRE2 − HB_PRE)
NOTE: Computed only if hb_pre2 > hb_pre. This index is used for hb_post calculation but it is not saved (see 3.2 on page 39)

4.3) **DFO Patient treated with a transfusion in 1 day with calculated hb_post and Patient L1**

Index = $\frac{transfused\ amount\ pure\ GR}{\{[average\ observed\ hb\ fall * (\text{check}\ date - previous\ date\ \text{in})] + \text{check}\ hb - previous\ hb\ pre\}}$
INFUS_SETT = GRAMMI_TRAS / (MED_DECR * (DATA_CONTR −DATA_INGR_PREC) + HB_CONTR −HB_PRE_PREC) INFUS_SETT = GRAMMI_TRAS / (MED_DECR * (DATA_CONTR −DATA_INGR_PREC))
NOTE: If (HB_CONTR <= HB_PRE_PREC) the second formula. Is used

5.APPUNTAMENTO

Next control = $\frac{(hb\ post - hb\ pre\ desired)}{previous\ expected\ hb\ fall} + previous\ date\ out$
APPUNTAMENTO = ((HB_POST − HB_FIX_PREC) / DECR_TEORICO_PREC) + DATA_USC_PREC
NOTE: **I**f saturday −1 if sunday +1

6.DECR_REALE

Observed hb fall = $\frac{(previous\ hb\ post - hb\ pre)}{transfusional\ interval}$
DECR_REALE = (HB_POST_PREC − HB_PRE) / INTERVALLO
NOTE: Computed only if interval > 0 and if previous hb post and hb pre are not equal to 0

7.DECR_PERC

% hb fall = $\frac{(observed\ hb\ fall * 100)}{previous\ hb\ post}$
DECR_PERC = (DECR_REALE * 100) / HB_POST_PREC
NOTE: Computed if previous hb_post > 0

8.MG_KG1 e MG_KG2

Mg kg desferal e Mg kg L1 = $\frac{(dose * 1000)}{last\ weight}$
MG_KG1 = (DOSE1 * 1000) / PESO MG_KG2 = (DOSE2 * 1000) / PESO
NOTE: Computed onlyy if weight > 0

9.N1

Desferal infusions number =		
	N1	$if\ N1 \geq 0$
	$\frac{(intertransfusional\ interval * weekly\ prescribed\ infusions)}{7} + N1$	$if\ N1 < 0$
	$\frac{(intertransfusional\ interval * weekly\ prescribed\ infusions)}{7}$	$if\ N1 = '*'$
N1 = ((INTERVALLO * FREQUENZA1) / 7) + N1		
NOTE: N1 > 0 means the number of infusions done, N1 < 0 means jumped infusions , N1 = star means that all prescribed infusions have been done		

10.N2

L1 administrations number =		
	N2	$if\ N2 \geq 0$
	$(interval * prescribed\ administrations\ die) + N2$	$if\ N2 < 0$
	$(interval * prescribed\ administrations\ die)$	$if\ N2 = '*'$
N2 = (INTERVALLO * FREQUENZA2) + N2		
NOTE: N2 > 0 means the number of administrations done, N2 < 0 means jumped administrations N2 = star means that all prescribed administrations have been done		

11.COMPLIANCE1

Compliance Desferal = $round\left[\frac{infusions\ number}{\frac{(interval * weekly\ prescribed\ infusions)}{7}} * 100\right]$
COMPLIANCE1 = round ((N1 / (INTERVALLO * FREQUENZA1) / 7) * 100)
NOTE: Computed if interval, frequency anf infusions number > 0

12.COMPLIANCE2

Compliance L1 = $round\left[\frac{administrations\ number}{(interval * administrations\ prescribed\ die)} * 100\right]$
COMPLIANCE2 = round ((N2 / (INTERVALLO * FREQUENZA2)) * 100)
NOTE: Calcolato se intervallo, frequenza e numero somministrazioni maggiori di 0

13. CONCENTRAZIONE

Desferal concentration= $\frac{dose * 100}{dilution}$
CONCENTRAZIONE = DOSE1 * 100 / DILUIZIONE
NOTE: Computed if dilution > 0

14. R1

Expected Desferal infusions number = $\frac{interval * weekly\ prescribed\ infusions}{7}$

R1 = INTERVALLO * FREQUENZA1 / 7

15. R2

Expected L1 administrations number = $interval * daily\ prescribed\ administrations$
R2 = INTERVALLO * FREQUENZA2

INTENSIV CHELATION FILE

16. DURATA

Time days = $end\ date - begin\ date + \frac{(end\ hour - begin\ hour)}{24} + \frac{(end\ minutes - begin\ minutes)}{(24 * 60)}$
DURATA = DATA_FINE _ DATA_INIZIO + (ORA_FINE − ORA_INIZIO) / 24 + (MINUTI_FINE − MINUTI_INIZIO) / (24 * 60)

17. QUANTITA

DF prescribed IV (periferal way) = $daily\ prescription * durata\ ricovero$ **DF prescribed CVC (catetere ways) =** $total\ prescription$
QUANTITA = QUANTITA * DURATA
NOTE: 'DF prescribed CVC' means DFO presents in every vaschetta to infuse during the prescribed period. 'DF prescribed IV' means daily prescription.

18. DFO

Administered amount = $prescribed\ amount - \frac{(residual\ ml. * prescribed\ amount)}{volume}$
DFO = QUANTITA − (ML_RESIDUI * QUANTITA) / VOLUME
NOTE: Computed if volume > 0

20. FE_ELIMINA

Excreted iron = $sideruria * duration$
FE_ELIMINA = SIDERURIA* DURATA
NOTE: **If** sideruria isnull , it is used the previous value of sideruria

21. DFO_MG_KG

Administered amount pro kg die = $\frac{administered\ amount * 1000}{weight * duration}$
DFO_MG_KG = (DFO * 1000) / (PESO * DURATA)
NOTE: Computed if weight > 0

SIDERURIA FILE

22. SID_MG_KG

Sideruria pro Kg = $\frac{total\ sideruria}{weight}$
SID_MG_KG = SIDERURIE / PESO
NOTE: Computed if weight > 0

23. HB

Haemoglobin = $previous\ hb\ post - [average\ observed\ hb\ fall * (sampling\ date - previous\ date\ out)]$
HB = HB_POST_PREC − (MED_DECR_REALE * (DATA_RACCOLTA − DATA_USCITA_PREC))
NOTE: Hb post and date out are of the last day hospital before sampling date (with hb post and date out not null) d

SUMMARY FILE

24. ETÀ

Age = $\frac{(current\ date - birth\ date)}{365}$
ETA= (DATA_ATTUALE − DATA_NASCITA) / 365
NOTE: Age is in years

25. NUM_TRASF

Transfusions number = $transfusion\ numbers\ of\ previous\ year + transfusions\ number\ of\ current\ year$
NUM_TRASF = NUM_TRASF_ANNO_PRECEDENTE + NUM_TRASF_ANNUALI

26. CONSUMO

Blood requirement = $\frac{transfused\ amount * 0.93}{average\ weight} * \frac{365}{days}$
CONSUMO = (QT_TRASFUSA * 0.93 / PESO_MEDIO) * 365 / GIORNI
NOTE: 'days' means 365 in case of complete year, or the number of days from the begin of the year to current date

27. HB_MEDIA

Mean Hb = $\frac{(\sum hb\ pre + \sum hb\ post)}{(number\ hb\ pre + number\ hb\ post)}$
HB_MEDIA = (∑ HB_PRE + ∑ HB_POST) / (number_hb_pre + number_hb_post)

28. FE_INTROD

Iron in = $transfused\ amount * 1.16 * 0.93$
FE_INTROD = QT_TRASFUSA * 1.16 * 0.93

29. FE_ELIM

Desferal Patient

Excrated Iron = $\sum (infusions\ number * sideruria) + iron\ eventually\ excreted\ with\ intensiv\ chelation$
FE_ELIM = ∑ (NUMERO_INFUS * SIDERURIA) + SOMMA_FE_ELIM
NOTE: Sideruria means the sideruria done before the hospitalization used in calculations

L1 Patient

Excrated Iron = $\frac{\sum (administrations\ number * sideruria)}{prescribed\ daily\ mean\ administrations}$
FE_ELIM = (∑ (NUMERO_SOMM * SIDERURIA) / MED_SOMMINISTR)
NOTE: Sideruria means the sideruria done before the hospitalization used in calculations

30.FE_INTR_T e FE_ELIM_T

Introduced Iron pro kg die = $\frac{introduced\ iron}{weight * days}$ **Excrated Iron pro kg die** = $\frac{excreted\ iron}{weight * days}$
FE_INTR_T = FE_INTROD / (PESO * GIORNI) FE_ELIM_T = FE_ELIM / (PESO * GIORNI)
NOTE: 'days' means 365 in case of complete year, or the number of days from the begin of the year to current date

31. Yearly average of:

Hb_pre_trasfusionale
Hb_post_trasfusionale
% decrease
Weight
ALT
LIC
Ferritin
Compliance (with two compliances during a hospitalization, calculate average for L1 and DFO)

TRANSFUSION REQUESTS FILE

32.TOT_EMAZIE

Amount of red blood cells = $\frac{(hb\ post - hb\ pre) * average\ index\ last\ six\ month}{average\ transfused\ units\ hematocrit}$
TOT_EMAZIE = (HB_POST − HB_PRE)* MED_FABB / EMATOCRITO
NOTE: Hb_post and hb_pre are taken from the last hospitalization with not null values

33.DATA_SACCA1

Transfusion date = $\text{check date} + \frac{(hb\ at\ \text{check} - hb\ desired\ at\ next\ \text{check})}{average\ observed\ hb\ fall\ during\ last\ six\ month}$
DATA_SACCA1 = DATA_CONTROLLO + (HB_CONTR − HB_FIX) /MED_DECR
NOTE: Hb desired at next check is taken from the last hospitalization with a not null value

DEFERIPRONE FILE (L1)

34.ERITRO_CORR

Absoluted NRBC count= $\frac{\%\,NRBC * total\ nucleated\ cells}{(100+\%\,NRBC)}$	
ERITRO_ASS = ERITRO_PERC * NUCLEATE_TOT / (100 + ERITRO_PERC)	

35.GLOBULI_B_CORR

Corrected white cells count= $\frac{total\ nucleated\ cells}{(1+\frac{\%\,NRBC}{100})}$	
GLOBULI_B_CORR = NUCLEATE_TOT / (1+ ERITRO_PERC/100)	
NOTE: **If** % NRBC is null it is substituted with 0	

36. NEUTRO_CORR

Absolut neutrophils count = $\frac{\%\,neutrophils * corrected\ \text{white}\ cells\ count}{100}$	
NEUTRO_CORR = NEUTRO_PERC * GLOBULI_B_CORR/ 100	

37.CP_RIMASTE

Tablets left = $tablets\ delivered\ at\ previous\ \text{check} + tablets\ \text{left}\ at\ previous\ \text{check} - tablets\ pro\ die * (\text{check}\ date - previous\ \text{check}\ date)$	
CP_RIMASTE = CP_CONSEGNATE_PREC + CP_RIMASTE_PREC − CP_DIE * (DATA_CONTR −DATA_CONTR_PREC)	

38.HB_POST DAY HOSPITAL PREVIOUS FOLLOW UP

HB post= $hb\ follow\ up + \left[average\ observed\ hb\ fall * (follow\ up\ date - previous\ hospitalization\ date) \right]$	
HB_POST=HB_CONTR+ (MED_DECR * (DATA_CONTR − DATA_INGR_PREC))	
NOTE:	A warning is shown if (follow up date − previous date in) > 10 days. The ricalculation is possible only for the first follow up next the hospitalization. See point 3.3 at page 39

Note: If, in case of DAY HOSPITAL, the date of admission corresponds to the follow up date, the calculated fields ERITRO_CORR, GLOBULI_B_CORR and NEUTRO_CORR are reported on this one.

Appendix B −File format

Every field of a file is characterized by a name, a type, and a description.
The field can be pre−assigned (and will appear in the input mask with a value − or it will not appear, though initialised), or will be assigned a value, resulting from calculations that involve other fields (of course if these are increased in the input phase).

Captions: Type of data: CHAR(N) string field, N characters max.
DATA chronological date field
NUM(X.Y) numerical field, X digits max, Y of which are decimal digits

The fields *"not used"* are included in the database for compatibility with the files of the previous program COMPUTHAL.

Personal Data File

File containing the patients' personal data, as well as fields associated to the patient but used in other files (such as code L1 for file L1, and all fields containing the programs displayed in the relevant cards).

Num	*Name*	*Type*	*Default/Formula*	*Description*
1	C_FISCALE	CHAR(16)		Fiscal code
2	CAP	CHAR(6)		Zip code
3	CARDIO_SINTO	CHAR(50)		Pre clinical Cardiopaty
4	CARDIO_SRU	CHAR(50)		Clinical Cardiopaty
5	CAUSA_MORTE	CHAR(25)		Death cause
6	CENTRO	CHAR(50)	assigned	Hospital center
7	CODICE_L1	CHAR(18)		L1 code
8	COGNOME	CHAR(25)		Surname
9	COM_NASC	CHAR(35)		Birth city
10	COMP_COD_FREE	CHAR(10)		Free Complication Cod
11	COMP_DATA_FREE	DATA		Free Complication date
12	COMP_FREE	CHAR(20)		Free complication
13	COMP1	CHAR(7)	copied from DH	Complication type
14	COMP10	CHAR(7)	copied from DH	Complication type
15	COMP2	CHAR(7)	copied from DH	Complication type
16	COMP3	CHAR(7)	copied from DH	Complication type
17	COMP4	CHAR(7)	copied from DH	Complication type
18	COMP5	CHAR(7)	copied from DH	Complication type
19	COMP6	CHAR(7)	copied from DH	Complication type
20	COMP7	CHAR(7)	copied from DH	Complication type
21	COMP8	CHAR(7)	copied from DH	Complication type
22	COMP9	CHAR(7)	copied from DH	Complication type
23	COMUNE	CHAR(35)		City
24	D_1TRASF	DATA		First transfusion date
25	D_2TRASF	DATA		Transfusion date
26	D_CHEL	DATA		Begin of chelation date
27	D_DIAGNOSI	DATA		Diagnosis date
28	D_EMO	DATA		Blooad group definition date
29	D_HBSAG	DATA		Hbs date (eventuallly)
30	D_HCV	DATA		Hcv positive date (eventually)
31	D_HIV	DATA		Hiv positive date (eventually)
32	D_POSIZION	DATA	not used	
33	D_REAZ	DATA	copied from DH	Reaction date (eventually)
34	D_SPLENECT	DATA		Splenectomy date (if done)
35	D_TRAPIANTO	DATA		Transplantation date(if done)
36	DATA_CARDIO_SINTO	DATA		Pre clinical cardiopaty date
37	DATA_CARDIO_STRU	DATA		Clinical cardiopaty date
38	DATA_MORTE	DATA		Death date
39	DATA1_CARDIO_SINTO	DATA		Pre clinical cardiopaty date

Num	Name	Type	Default/Formula	Description
40	DATA1_CARDIO_STRU	DATA		Clinical cardiopaty date
41	DATAC1	DATA	copied from DH	Complication date
42	DATAC10	DATA	copied from DH	Complication date
43	DATAC2	DATA	copied from DH	Complication date
44	DATAC3	DATA	copied from DH	Complication date
45	DATAC4	DATA	copied from DH	Complication date
46	DATAC5	DATA	copied from DH	Complication date
47	DATAC6	DATA	copied from DH	Complication date
48	DATAC7	DATA	copied from DH	Complication date
49	DATAC8	DATA	copied from DH	Complication date
50	DATAC9	DATA	copied from DH	Complication date
51	DIAGNOSI	CHAR(50)		Thalassaemia diagnosis
52	EMO_GRUPPO	CHAR(3)		Blood group (A,B,0)
53	EMO_RH	CHAR(1)		Blood group Rh
54	GENOTIPO	CHAR(12)		Genotype
55	IDENTIFIER	CHAR(15)	assigned	
56	IMMUNIZZAZ	CHAR(15)		Immunizzation
57	INDIRIZZO	CHAR(35)		Adress
58	LIBRETTO	CHAR(15)		Sanitary book number
59	MEDICO	CHAR(20)		Doctor
60	MOSTDOC__KEY	CHAR(18)	assigned	Number Identification
61	N_ESENZIONE_TICKET	CHAR(20)		No Ticket Number
62	NATO	DATA		Birth date
63	NAZ_NASC	CHAR(20)		Birth nation
64	NAZIONALIT	CHAR(15)		Nationality
65	NAZIONE_RESID	CHAR(25)		Nation
66	NOME	CHAR(25)		Name
67	NOTE	CHAR(250)		Comments
68	PROG_CARDIO	CHAR(250)	Copied from cardiological card	Cardiological program
69	PROG_CHEL	CHAR(250)	copied from DH	Chelation program
70	PROG_CHEL_INT	CHAR(250)	Copied from intensiv chelation	Intensiv chelation program
71	PROG_CLINICA	CHAR(250)	copied from DH	Clinical program
72	PROG_EMATO	CHAR(250)	copied from DH	Examination program
73	PROG_STRUM	CHAR(250)	Copied from instrumental examination card	Instrumental check program
74	PROG_TERAPIA	CHAR(250)	copied from DH	Therapy program
75	PROG_TRASF	CHAR(250)	copied from DH	Transfusional program
76	PROV_RESID	CHAR(6)		Province
77	PROVINCIA	CHAR(25)		Province
78	SESSO	CHAR(50)		Sex
79	SPLENECTO	CHAR(1)		Splenectomy done (Y / N)
80	STATO	CHAR(50)	alive	Patient state (live/dead)
81	TELEFONO	CHAR(50)		Telephone number
82	TRASF_A	CHAR(35)		Transferred from
83	TRASF_DA	CHAR(35)		Transferred to
84	VISUAL_NOTE	CHAR(1)		Memo shown in main page
85	VISUAL1	CHAR(1)	copied from DH	
86	VISUAL10	CHAR(1)	copied from DH	
87	VISUAL2	CHAR(1)	copied from DH	
88	VISUAL3	CHAR(1)	copied from DH	
89	VISUAL4	CHAR(1)	copied from DH	
90	VISUAL5	CHAR(1)	copied from DH	
91	VISUAL6	CHAR(1)	copied from DH	
92	VISUAL7	CHAR(1)	copied from DH	
93	VISUAL8	CHAR(1)	copied from DH	
94	VISUAL9	CHAR(1)	copied from DH	

The following list shows the fields in the order of the input mask (the table includes the field description, the database field name and the reference number in the previous table):

Description	***Name***	***Number***
Surname	COGNOME	8
Name	NOME	66
Sex	SESSO	78
Birth Date	NATO	62
City of birth	COM_NASC	9
Province of birth	PROVINCIA	77
Nation of birth	NAZ_NASC	63
Nationality	NAZIONALIT	64
Adress	INDIRIZZO	57
City	COMUNE	23
Zip code	CAP	2
Province	PROV_RESID	76
Nation	NAZIONE_RESID	65
Telephone	TELEFONO	81
Fiscal code	C_FISCALE	1
Sanitary book number	LIBRETTO	58
No ticket number	N_ESENZIONE_TICKET	61
Transferred from	TRASF_DA	83
Transferred date	D_2TRASF	25
Transferred to	TRASF_A	82
Doctor	MEDICO	59
L1 code	CODICE_L1	7
Diagnosis	DIAGNOSI	51
Diagnosis date	DATA_DIAGNOSI	27
Blood group	EMO_GRUPPO	52
Phenotype	GENOTIPO	54
Blood group date	D_EMO	28
Immunizzation	IMMUNIZZAZ	56
First transfusion date	D_1TRASF	24
First chelation date	D_CHEL	26
Splenectomy date	D_SPLENECT	34
Transplantation date	D_TRAPIANTO	35
Hcv positivity date	D_HCV	30
Hiv positivity date	D_HIV	31
Hbs positivity date	D_HBSAG	29
Patient date	STATO	80
Death ate	DATA_MORTE	40
Death cause	CAUSA_MORTE	3
Memo	NOTE	67
Memo in main page	VISUAL_NOTE	84
Pre clinical cardiopaty	CARDIO_STRU	4
Pre clinical cardiopaty date	DATA_CARDIO_STRU	36
Pre clinical cardiopaty relevation date	DATA1_CARDIO_STRU	39
Clinical Cardiopaty	CARDIO_SINTO	5
Clinical cardiopaty date	DATA_CARDIO_SINTO	35
Clinical cardiopaty relevation date	DATA1_CARDIO_SINTO	38
Complication 1	COMP1	13

Description	*Name*	*Number*
Complication date 1	DATAC1	41
In main page 1	VISUAL1	85
Complication 2	COMP2	15
Complication date 2	DATAC2	43
In main page 2	VISUAL2	87
Complication 3	COMP3	16
Complication date 3	DATAC3	44
In main page 3	VISUAL3	88
Complication 4	COMP4	17
Complication date 4	DATAC4	45
In main page 4	VISUAL4	89
Complication 5	COMP5	18
Complication date 5	DATAC5	46
In main page 5	VISUAL5	90
Complication 6	COMP6	19
Complication date 6	DATAC6	47
In main page 6	VISUAL6	91
Complication 7	COMP7	20
Complication date 7	DATAC7	48
In main page 7	VISUAL7	92
Complication 8	COMP8	21
Complication date 8	DATAC8	49
In main page 8	VISUAL8	93
Complication 9	COMP9	22
Complication date 9	DATAC9	50
In main page 9	VISUAL9	94
Complication 10	COMP10	14
Complication date 10	DATAC10	42
In main page 10	VISUAL10	86
Free complication code	COMP_COD_FREE	10
Free complication type	COMP_FREE	12
Free complication date	COMP_DATA_FREE	11
Transfusional program	PROG_TRASF	75
Clinical program	PROG_CLINICA	71
Therapic program	PROG_TERAPIA	74
Emato chemical examination program	PROG_EMATO	72
Instrumental checks program	PROG_STRUM	73
Intensif chelation program	PROG_CHEL_INT	70
Therapy program	PROG_CHEL	69
Cardiological therapy program	PROG_CARDIO	68

Family tree− Tests file

File containing the personal data and doctors of the patients' relatives

Num	*Name*	*Type*	*Default/Formula*	*Description*
1	ABO	CHAR(3)		Blood group(AB0)
2	ALFA_NALFA	NUM(5,1)		Division alfa/not alfa at diagnosis
3	ANNO_NATO	NUM(4)	not used	
4	BETA	NUM(6,1)		Division beta/non alfa at diagnosis
5	COGNOME	CHAR(17)	copied from basic data	Surname patient or mother (before marriage)
6	COGNOME_P	CHAR(17)	copied from basic data	Surname patient
7	DATA_NASCITA	DATE	copied from basic data (updatable)	Birth date
8	DNA1	CHAR(8)		Beta genotype
9	DNA2	CHAR(8)		Beta genotype
10	DNA3	CHAR(5)		Alfa genotype
11	DNA4	CHAR(5)		Alfa genotype
12	DNA5	CHAR(8)		Other
13	DNA6	CHAR(8)		Other
14	DPN	CHAR(1)		Pre birth diagnosis (Y/N)
15	FREE1	CHAR(10)	not used	
16	FREE1_NOME	CHAR(10)	not used	
17	FREE2	CHAR(10)	not used	
18	FREE2_NOME	CHAR(10)	not used	
19	FREE3	CHAR(10)	not used	
20	FREE3_NOME	CHAR(10)	not used	
21	HB	NUM(5,1)		Hb at diagnosis
22	HBA2	NUM(5,1)		% HBA2 at diagnosis
23	HBF	NUM(6,1)		% HBF at diagnosis
24	HBS	NUM(6,1)		% HBS at diagnosis
25	HFE1	CHAR(20)		HFE1
26	HFE2	CHAR(20)		HFE2
27	HFE3	CHAR(20)		HFE3
28	HLA	CHAR(50)		HLA (compatible / not compatible)
29	IDENTIFIER	CHAR(15)	not used	
30	MCH	NUM(5,1)		MCH at diagnosis
31	MCV	NUM(6,1)		MCV at diagnosis
32	MOSTDOC__KEY	CHAR(18)	assigned	Unique identificator
33	NATO	DATE	copied from basic data	Patient birth date
34	NAZ_NASC	CHAR(20)	copied from basic data (updatable)	Patient birth nation
35	NOME	CHAR(17)	copied from basic data	Name
36	NOME_P	CHAR(17)	copied from basic data	Patient name
37	ORDINE	CHAR(1)		Parent order
38	PROVINCIA	CHAR(6)		Birth province
39	RH	CHAR(7)		Blood group Rh
40	SALUTE	CHAR(1)		Healthy, Sick, Carrier
41	SESSO	CHAR(1)		Sex
42	VIVO	CHAR(1)		Alive (Y/N)

The following list shows the fields in the order of the input mask (the table includes the field description, the database field name and the reference number in the previous table):

Description	***Name***	***Number***
Patient Surname	COGNOME_P	6
Patient name	NOME_P	36
Grade	ORDINE	37
Alive	VIVO	42
Healthy/Sick/Carrier	SALUTE	40
Parent surname	COGNOME	5
Parent name	NOME	35
Birth date	DATA_NASCITA	7
Birth province	PROVINCIA	38
Birth nation	NAZ_NASC	34
Sex	SESSO	41
Hb	HB	21
MCV	MCV	31
MCH	MCH	30
HbA2	HBA2	22
HbF	HBF	23
HbS	HBS	24
A genotype A (first part)	DNA1	8
A genotype A (second part)	DNA2	9
B genotype (first part)	DNA3	10
B genotype (second part)	DNA4	11
Other (second part)	DNA5	12
Other (second part)	DNA6	13
HLA	HLA	28
HFE1	HFE1	25
HFE2	HFE2	26
HFE3	HFE3	27
AB0	ABO	1
RH	RH	39

Day Hospital File

File containing the data relating to the patient Day Hospital

Num	*Name*	*Type*	*Default / Formula*	*Description*
1	AHAV	NUM(6,2)		aHAV
2	AHBC	NUM(6,2)		aHBC
3	AHBE	NUM(6,2)		aHBE
4	AHBS	NUM(6,2)		aHBS
5	AHIV	NUM(6,2)		aHIV
6	ALPH	NUM(6,2)		ALPH
7	ALT	NUM(4)		ALT
8	ALTRIESAMI	CHAR(100)		Name and result of other examinations
9	ANAMNESI	CHAR(26)		Anamnesis
10	APPUNTAM	DATE	Formula 5 page40	Next check date
11	AST	NUM(4)		AST
12	BIL_IND	NUM(6,2)		Ind bilirubina
13	BIL_TOT	NUM(6,2)		Total bilirubina
14	BMI	NUM(6,2)		Bmi
15	CA	NUM(6,2)		Calcio
16	CIRC_ADD	NUM(7,2)		Abdominal Circonference
17	CL	NUM(6,2)		Cl
18	COGNOME	CHAR(17)	Copied from basic data	Surname
19	COMPLIANCE_C1	NUM(3)		CRONO infusions
20	COMPLIANCE_C2	NUM(3)		MEMS administration
21	COMPLIANCE_R1	NUM(3)	Formula14 page41	Calcolated infusions
22	COMPLIANCE_R2	NUM(3)	Formula 15 page42	Calcolated administrations
23	COMPLIANCE1	NUM(5,2)	Formula 11 page41	Desferal Compliance
24	COMPLIANCE2	NUM(5,2)	Formula 12 page41	L1 Compliance
25	COMPLIANCE3	NUM(5,2)	previous value	Third drug compliance
26	COMPLIANCE4	NUM(5,2)	previous value	Fourth drug compliance
27	COMPLIANCE5	NUM(5,2)	previous value	Fifth drug compliance
28	COMPLIANCE6	NUM(5,2)	previous value	Sixth drug compliance
29	COMPLIANCED1	NUM(5,2)		First diet compliance
30	COMPLIANCED2	NUM(5,2)		Second diet compliance
31	COMPLICANZE	CHAR(20)	Copied to basic data	Complication
32	CREATININA	NUM(6,2)		Creatinina
33	DATA_COMPL	DATE		Complication date
34	DATA_CONTR	DATE	today	Haemoglobin check date
35	DATA_HB_PRE2	DATE		hb second day check date
36	DATA_INGR	DATE	today	Date in
37	DATA_PSACCA	DATE		First sac transfusion date
38	DATA_QSACCA	DATE		Second sac transfusion date
39	DATA_RSACCA	DATE		Third sac transfusion date
40	DATA_SSACCA	DATE		Fourth sac transfusion date
41	DATA_TSACCA	DATE		Fifth sac transfusion date
42	DATA_USACCA	DATE		Sixth sac transfusion date
43	DATA_USC	DATE	today	Date out
44	DATAR	DATE		Reaction date
45	DAY	CHAR(6)	not used	
46	DECR_PERC	NUM(6,2)	Formula 7 page40	% hb fall
47	DECR_REALE	NUM(6,2)	Formula 6 page40	Observed hb fall
48	DECR_TEOR	NUM(6,2)	Previous DECR_REALE	Teoric hb fall
49	DESF_DILUI	NUM(4,2)	not used	
50	DESF_REAZ	CHAR(8)		Transfusional reaction
51	DESF_SC	NUM(7,2)	not used	
52	DESF_X_KG	NUM(5)	not used	
53	DIETA1	CHAR(13)		First diet

Num	Name	Type	Default / Formula	Description
54	DIETA2	CHAR(13)		Second diet
55	DIM	CHAR(50)		Local reaction dimension
56	DOSE1	NUM(6,2)	Previous value	Desferal dose
57	DOSE2	NUM(5,1)	Previous value	L1 dose
58	DOSE3	NUM(6,2)	previous value	Other drug dose
59	DOSE4	NUM(6,2)	previous value	Other drug dose
60	DOSE5	NUM(6,2)	previous value	Other drug dose
61	DOSE6	NUM(6,2)	previous value	Other drug dose
62	DURATA	CHAR(2)		DFO reaction lasting
63	ELETTRO	NUM(6,2)		% NRBC
64	ERITRO_ASS	NUM(6,2)	Formula 34 pag 44	Absolut NRBC
65	ESTRAD	NUM(6,2)		Estrad / Testosteron
66	FARMACO1	CHAR(13)	not used	
67	FARMACO2	CHAR(13)	not used	
68	FARMACO3	CHAR(13)	previous value	First drug
69	FARMACO4	CHAR(13)	previous value	Second drug
70	FARMACO5	CHAR(13)	previous value	Third drug
71	FARMACO6	CHAR(13)	previous value	Fourth drug
72	FARMACO7	CHAR(13)	previous value	Fifth drug
73	FARMACO8	CHAR(13)	previous value	Sixth drug
74	FARMACO9	CHAR(13)	previous value	Seventh drug
75	FARMACOA	CHAR(13)	previous value	Other drug
76	FARMACOB	CHAR(13)	previous value	Other drug
77	FARMACOC	CHAR(13)	previous value	Other drug
78	FARMACOD	CHAR(13)	previous value	Other drug
79	FARMACOE	CHAR(13)	previous value	Other drug
80	FEGATO	NUM(4,2)		Liver margin
81	FEQ	CHAR(2)		% DFO frequency reaction
82	FERRITINA	NUM(5)		Ferritin
83	FIBRI	NUM(6,2)		INR
84	FILTRATE	CHAR(1)	Filtrated in bed	Sacs type
85	FOLATI	NUM(6,2)		Folati
86	FREE1	CHAR(10)		Blood test dosage
87	FREE1_DOSE	CHAR(3)	not used	
88	FREE1_NOME	CHAR(10)		Blood test
89	FREE2	CHAR(10)		Blood test dosage
90	FREE2_DOSE	CHAR(3)	not used	
91	FREE2_NOME	CHAR(10)		Blood test
92	FREE3	CHAR(10)		Blood test dosage
93	FREE3_DOSE	CHAR(3)	not used	
94	FREE3_NOME	CHAR(10)		Blood test
95	FREE4	CHAR(10)		Blood test dosage
96	FREE4_DOSE	CHAR(3)	not used	
97	FREE4_NOME	CHAR(10)		Blood test
98	FREE5	CHAR(10)		Blood test dosage
99	FREE5_DOSE	CHAR(3)	not used	
100	FREE5_NOME	CHAR(10)		Blood test
101	FREE6	CHAR(10)		Blood test dosage
102	FREE6_DOSE	CHAR(3)	not used	
103	FREE6_NOME	CHAR(10)		Blood test
104	FREQ_CARD	NUM(5,2)		Hearth frequency
105	FREQUENZA1	NUM(3)		Desferal frequency
106	FREQUENZA2	NUM(3)		L1 frequency
107	FREQUENZA3	CHAR(8)	previous value	First drug frequency
108	FREQUENZA4	CHAR(8)	previous value	Second drug frequency
109	FREQUENZA5	CHAR(8)	previous value	Third drug frequency
110	FREQUENZA6	CHAR(8)	previous value	Other drug frequency
111	FREQUENZA7	CHAR(8)	previous value	Other drug frequency

Num	Name	Type	Default / Formula	Description
112	FREQUENZA8	CHAR(8)	previous value	Other drug frequency
113	FREQUENZA9	CHAR(8)	previous value	Other drug frequency
114	FREQUENZAA	CHAR(8)	previous value	Other drug frequency
115	FREQUENZAB	CHAR(8)	previous value	Other drug frequency
116	FREQUENZAC	CHAR(8)	previous value	Other drug frequency
117	FREQUENZAD	CHAR(8)	previous value	Other drug frequency
118	FREQUENZAE	CHAR(8)	previous value	Other drug frequency
119	FRUTTOS	NUM(6,2)		Fruttos
120	FSH	NUM(6,2)		FSH
121	FT4	NUM(6,2)		FT4
122	FTG	NUM(7,2)		FTG
123	GAMMAGT	NUM(6,2)		GammaGT
124	GLICEMIA	NUM(6,2)		Glicemy
125	GLICEMIA_BASALE	NUM(7,2)		Basal Glicemy
126	GLICEMIA_POST	NUM(7,2)		Post Glicemy
127	GLOBULI_B_CORR	NUM(6,2)	Formula 35 pag 44	Absoluted white blood cells
128	GRAMMI_TRAS	NUM(5,1)	Formula 1 page 39	Transfused DFO amount
129	GRAMMI_TRASF_P	NUM(6,2)		Prescribed transfused DFO amount
130	GRAVI	CHAR(2)		DFO reaction gravity
131	HB_CONTR	NUM(5,1)		Hb at check
132	HB_FIX	NUM(5,1)		Desired hb pre
133	HB_POST	NUM(5,1)	Formula 3 pag 39	Hb post
134	HB_POST_TIPO	CHAR(1)		Type HB post
135	HB_PRE	NUM(5,1)		Hb pre
136	HB_PRE2	NUM(5,1)		Desired hb pre
137	HBC	NUM(6,2)		HBC
138	HBS	NUM(6,2)		HBS
139	HCV	NUM(6,2)		HCV
140	HCV_RIBA	CHAR(5)		HCV_RIBA
141	HCV_RNA	CHAR(10)		HCV_RNA
142	HCV_UNITA	CHAR(50)		HCV_RNA units
143	HCVRNA	CHAR(50)		HCV_RNA (+ / −)
144	HT_PSACCA	NUM(6,2)	0.8	Hematocrit
145	HT_QSACCA	NUM(6,2)	0.8	Hematocrit
146	HT_RSACCA	NUM(6,2)	0.8	Hematocrit
147	HT_SSACCA	NUM(6,2)	0.8	Hematocrit
148	HT_TSACCA	NUM(6,2)	0.8	Hematocrit
149	HT_USACCA	NUM(6,2)	0.8	Hematocrit
150	IDENTIFIER	CHAR(15)	copied from basic data	
151	INFUS_SETT	NUM(4)	Formula 4 page40	Index
152	INSULINA	NUM(6,2)		Insul
153	INTERVALLO	NUM(4)	Formula 2 page 39	Transfusional interval
154	K	NUM(6,2)		Potassio
155	LDH	NUM(6,2)		LDH
156	LEUCO	NUM(6,2)		White blood cells
157	LH	NUM(6,2)		LH
158	LIC	NUM(6,2)		LIC
159	MEDICO	CHAR(20)		Docto who visit
160	MG	NUM(6,2)		Mg
161	MG_KG1	NUM(5,1)	Formula 8 page40	mg/kg Desferal
162	MG_KG2	NUM(5,1)	Formula 8 page40	mg/kg L1
163	MILZA	NUM(4,2)		Spleen
164	MOSTDOC__KEY	CHAR(18)	assigned	Unique identificator
165	N1	NUM(3)	Formula 9 page41	Jumped desferal infusions
166	N2	NUM(3)	Formula 10 page41	Jumped L1 administrations
167	NA	NUM(6,2)		Sodio
168	NATO	DATE	Copied from basic data	Birth date

Num	Name	Type	Default / Formula	Description
169	NEUTRO	NUM(6,2)		Neutrophils
170	NOME	CHAR(17)	Copied from basic data	Name
171	NOTE1	CHAR(20)		Comments
172	NOTE2	CHAR(20)		Comments
173	NUCLEATE	NUM(6,2)	Formula 34 pag 44	Nucleatee
174	NUM_INF_SC	NUM(2)	not used	
175	OBIET	CHAR(70)		Phisical examination
176	P	NUM(6,2)		P
177	PAOS	NUM(9,2)		Paos
178	PESO	NUM(6,1)		Weight
179	PIASTRINE	NUM(6,2)		Platelets
180	PRO_LATT	NUM(6,2)		PRL
181	PROVV	CHAR(30)		Reaction therapy
182	PSACCA	CHAR(10)		Number first sac
183	PT	NUM(6,2)		PT
184	PTT	NUM(6,2)		PTT
185	Q_PSACCA	NUM(4)		Hematocrit
186	Q_QSACCA	NUM(3)		Hematocrit
187	Q_RSACCA	NUM(4)		Hematocrit
188	Q_SSACCA	NUM(3)		Hematocrit
189	Q_TSACCA	NUM(3)		Hematocrit
190	Q_USACCA	NUM(4)		Hematocrit
191	QSACCA	CHAR(10)		Fourth sac number
192	REAZIONI	CHAR(14)	NO	L1 reactions
193	RSACCA	CHAR(10)		Fifth sac number
194	SEDE	CHAR(2)		DFO reactions point (1 − 14)
195	SEDI	CHAR(40)		Local reactions
196	SGOT	NUM(4)	not used	
197	SGPT	NUM(4)	not used	
198	SIDER_SC	NUM(7,2)		Sideruria
199	SIDEREMIA	NUM(7,2)		Siderемia
200	SSACCA	CHAR(10)		Second sac number
201	STATURA	NUM(7,2)		Height
202	SUPERF	NUM(6,2)		Body surface
203	TEMPO	CHAR(2)		Time of appearence
204	TERAP_REAZ	CHAR(27)		Pre Reaction Therapy
205	TERAP_REAZ_POST	CHAR(100)		Post Reaction Therapy
206	TERAPIA	CHAR(22)	not used	
207	TIPO	CHAR(6)	not used	
208	TIPO_DESF	CHAR(2)	not used	
209	TIPO_INF	CHAR(50)		Desferal type
210	TIPO_LIC	CHAR(50)		LIC type
211	TIPO_SIST_LOC	CHAR(50)		Reaction type (systemic / local)
212	TIPO_VISITA	CHAR(50)		Hospitalization type (DHT / DHNT/ Ambulatorial)
213	TIPOR	CHAR(2)		DFO reaction type
214	TR_INX	NUM(6,2)		Tr Index
215	TRANSFERRINE	NUM(7,2)		Transferrin value
216	TSACCA	CHAR(10)		Third sac number
217	TSH	NUM(7,2)		TSH value
218	UNITA3	CHAR(8)		Other drug measure unit
219	UNITA4	CHAR(8)		Other drug measure unit
220	UNITA5	CHAR(8)		Other drug measure unit
221	UNITA6	CHAR(8)		Other drug measure unit
222	URIC	NUM(6,2)		Uricemy
223	USACCA	CHAR(10)		Sixth sac number
224	VITA	NUM(6,2)		A vitamin
225	VITC	NUM(6,2)		C vitamin
226	VITC_DOSE	NUM(5,2)	previous value	C vitamin dose

Num	Name	Type	Default / Formula	Description
227	VITE	NUM(6,2)		E vitamin
228	ZN	NUM(6,2)		Zn

The following list shows the fields in the order of the input mask (the table includes the field description, the database field name and the reference number in the previous table):

Description	Name	Number
Surname	COGNOME	18
Name	NOME	170
Birth Date	NATO	168
Clinic program	PROG_CLINICO	In basic data
Check type	TIPO_VISITA	212
Date in	DATA_INGR	36
Date out	DATA_USC	43
Phisical examination	ANAMNESI	9
History	OBIET	175
Heart rate	FREQ_CARD	104
Paos	PAOS	177
Weight	PESO	178
Height	STATURA	201
Liver	FEGATO	80
Spleen	MILZA	163
Abdominal Circ.	CIRC_ADD	16
Physician	MEDICO	159
Transfusional program	PROG_TRASF	In basic data
Sacs type	FILTRATE	84
First sac number	PSACCA	182
First sac volume	HT_PSACCA	144
First sac hematocrit	Q_PSACCA	185
First sac transfusion date	DATA_PSACCA	37
Second sac number	SSACCA	200
Secon sac volume	HT_SSACCA	147
Second sac hematocrit	Q_SSACCA	188
Second sac transfusion date	DATA_SSACCA	40
Third sac number	TSACCA	216
Third sac volume	HT_TSACCA	148
Third sac hematocrit	Q_TSACCA	189
Third sac transfusion date	DATA_TSACCA	187
Forth sac number	QSACCA	191
Forth sac volume	HT_QSACCA	145
Forth sac hematocrit	Q_QSACCA	186
Forth sac transfusion date	DATA_QSACCA	38
Fifth sac number	RSACCA	193
Fifth sac volume	HT_RSACCA	146
Fifth sac hematocrit	Q_RSACCA	187
Fifth sac transfusion date	DATA_RSACCA	39
Sixth sac number	USACCA	223

Description	*Name*	*Number*
Sixth sac volume	HT_USACCA	149
Sixth sac hematocrit	Q_USACCA	190
Sixth sac transfusion date	DATA_USACCA	42
Prescribed amount	GRAMMI_TRASF_P	129
Tranfused amount	GRAMMI_TRAS	128
Reactions	REAZIONI	192
Pre therapy	TERAP_REAZ	204
Post therapy	TERAP_REAZ_POST	205
Check date	DATA_CONTR	34
Hb at check	HB_CONTR	131
Hb pre transfusional	HB_PRE	135
Hb post transfusional	HB_POST	133
Hb post type	HB_POST_TIPO	134
Pre2 check date	DATA_HB_PRE2	35
Hb pre second date	HB_PRE2	136
Index	INFUS_SETT	151
Hb fall observed	DECR_REALE	47
% hb fall	DECR_PERC	46
Hb fall expected	DECR_TEOR	48
Hb pre desired	HB_FIX	132
Next control date	APPUNTAM	10
Chelation program	PROG_CHEL	In basi c data
Desferal infusion type	TIPO_INF	209
Desferal total dose	DOSE1	56
Desferal dilution	DESF_DILUI	49
Infusion regim	FREQUENZA1	105
Infusions Crono	COMPLIANCE_C1	19
Infusions given	N1	165
L1 dose	DOSE2	57
L1 pro die dose	FREQUENZA2	106
MEMS administrations	COMPLIANCE_C2	20
Given administrations	N2	166
Therapy reactions	DESF_REAZ	50
Ascorbic acid dosage	VITC_DOSE	226
Note	NOTE1	171
Reaction type	TIPO_SIST_LOC	211
Reaction date	DATAR	44
Reaction description	TIPOR	213
Reaction severity	GRAVI	130
Reaction dimension	DIM	55
Reaction latency	TEMPO	203
Reaction lasting	DURATA	62
Treatment	PROVV	181
First drug	FARMACO3	68
First drug prescription	FREQUENZA3	107
Second drug	FARMACO4	69
Second drug prescription	FREQUENZA4	108
Third drug	FARMACO5	70

Description	*Name*	*Number*
Third drug prescription	FREQUENZA5	109
Forth drug	FARMACO6	71
Forth drug prescription	FREQUENZA6	110
Fifth drug	FARMACO7	72
Fifth drug prescription	FREQUENZA7	111
Sixth drug	FARMACO8	73
Sixth drug prescription	FREQUENZA8	112
Other drug	FARMACO9	74
Other drug prescription	FREQUENZA9	113
Other drug	FARMACOA	75
Other drug prescription	FREQUENZAA	114
Other drug	FARMACOB	76
Other drug prescription	FREQUENZAB	115
Other drug	FARMACOC	77
Other drug prescription	FREQUENZAC	116
Other drug	FARMACOD	78
Other drug prescription	FREQUENZAD	117
Other drug	FARMACOE	79
Other drug prescription	FREQUENZAE	118
Diet	DIETA1	53
Diet Compliance	COMPLIANCED1	29
Diet Compliance	DIETA2	54
Diet Compliance	COMPLIANCED2	30
Complication	COMPLICANZE	31
Complication date	DATA_COMPL	33
Examination program	PROG_EMATO	From basic data
White blood cells	LEUCO	156
Neutrophils	NEUTRO	169
Erythroblasts	ELETTRO	54
Platelets	PIASTRINE	179
Ferritin	FERRITINA	82
Serum iron	SIDEREMIA	199
Transferrin	TRANSFERRINE	215
Ast	AST	11
Alt	ALT	7
gGT	GAMMAGT	123
ALP	ALPH	6
LDH	LDH	155
Tot Bil	BIL_TOT	13
Creat	BIL_IND	12
NA	NA	167
K	K	154
Ca	CA	15
P	P	176
Mg	MG	160
PTT	PTT	184
INR	FIBRI	83
Glycemia	GLICEMIA	124

Description	*Name*	*Number*
Fruttos	FRUTTOS	119
Insul	INSULINA	152
TSH	TSH	217
fT4	FT4	121
LH	LH	157
FSH	FSH	120
Estradiol	ESTRAD	64
PRL	PRO_LATT	180
LIC	TIPO_LIC	210
Transferrin Index	TR_INX	214
Serum Uric Acid	URIC	222
HCV	HCV	139
HCV Riba	HCV_RIBA	140
HCV RNA(+/−)	HCVRNA	143
HCV RNA (value)	HCV_RNA	141
HCV RNA (measur unit)	HCV_UNITA	142
HBsAg	HBS	138
HBs Ab	AHBS	4
HAV Ab	AHAV	1
HIV Ab	AHIV	5
Other examination	FREE1_NOME	88
Other examination dose	FREE1	86
Other examination	FREE2_NOME	91
Other examination dose	FREE2	89
Other examination	FREE3_NOME	94
Other examination dose	FREE3	92
Other examination	FREE4_NOME	97
Other examination dose	FREE4	95
Other examination	FREE5_NOME	100
Other examination dose	FREE5	98
Other examination	FREE6_NOME	103
Other examination dose	FREE6	101

Intensive chelation file

File containing the intensive chelation data

Num	*Name*	*Type*	*Default / Formula*	*Description*
1	COGNOME	CHAR(17)	copied from basic data	Surname
2	DATA_FINE	DATE	today	End chelation Date
3	DATAINIZIO	DATE	today	Begin chelation date
4	DESF_KGDIE	NUM(6,1)	Formula 19 page	Desferal pro kg/die
5	DFO	NUM(6,1)	Formula 18 page42	Desferal infused
6	DFO_MG_KG	NUM(5,1)	Formula 21 page42	mg Desferal infused pro kg
7	DURATA	NUM(6,1)	Formula 16 page42	Lasting
8	FE_ELIMINA	NUM(4)	Formula 20 page42	Sideremy out
9	FERRITINA	NUM(5)	Copied from last card	Ferritin
10	FREE1	CHAR(10)	not used	
11	FREE1_NOME	CHAR(10)	not used	
12	FREE2	CHAR(10)	not used	
13	FREE2_NOME	CHAR(10)	not used	
14	GG_INFUS	NUM(3,1)		Infusion days
15	IDENTIFIER	CHAR(15)	not used	
16	LOTTO_AGO	NUM(5)	not used	
17	MIN_FINE	NUM(2)	00	End chelation minutes
18	MIN_INIZIO	NUM(2)	00	Begin chelation minutes
19	ML_RESIDUI	NUM(4)		Ml left (only via catetere chelation)
20	MOSTDOC__KEY	CHAR(18)	assigned	Unique Identificator
21	NATO	DATE	copied from basic data	Birth date
22	NOME	CHAR(17)	copied from basic data	Name
23	NUM_BUCHI	NUM(1)	not used	
24	ORA_FINE	NUM(2)	12	End chelation hour
25	ORA_INIZIO	NUM(2)	00	Start chelationhour
26	PESO	NUM(5,1)	Copied from last card	Weight
27	PROBLEMI	CHAR(30)		Problems
28	QUANTITA	NUM(5,1)		Amount
29	SGPT	NUM(4)	Copied from last card	ALT
30	SIDERURIA	NUM(6,1)	Copied from last sideruria	Sideruria
31	TIPO	CHAR(1)	Periferal vein	Chelation type (Periferal vein / Via catetere)
32	TIPO_AGO	CHAR(15)	not used	
33	VIT_C_DOSE	NUM(3)	Copied from last card	Ascorbic acid dose
34	VITC_PLASM	NUM(6,2)	not used	
35	VOLUME	NUM(3)		Volume

he following list shows the fields in the order of the input mask (the table includes the field description, the database field name and the reference number in the previous table):

Description	*Name*	*Number*
Patient Surname	COGNOME	6
Patient name	NOME	36
Birth date	NATO	21
Program	PROG_CHEL	From basic data
Chelation type	TIPO	31
Desferal prescribed	DFO	5
Volume	VOLUME	36
Chelation lasting	GG_INFUS	14

Description	*Name*	*Number*
Lasting type	TIPO_DURATA	33
Begin date	DATAINIZIO	3
Begin hour	ORA_INIZIO	25
Begin minutes	MIN_INIZIO	18
End date	DATA_FINE	2
End hour	ORA_FINE	24
End minutes	MIN_FINE	17
Left volume	ML_RESIDUI	19
Weight	PESO	26
Urinary iron excretion	SIDERURIA	30
Ascorbi c acid	VIT_C_DOSE	34
Notes	PROBLEMI	27

Transfusion requests file

File containing data on requests for transfusion

Num	*Name*	*Type*	*Default / Formula*	*Description*
1	COGNOME	CHAR(25)	Copied from basic data	Surname
2	DATA_COMP	DATE	today	Compilation date
3	DATA_CONTROLLO	DATE	today	Check date
4	DATA_SACCA1	DATE	Formula 33 page	First transfusion date
5	DATA_SACCA4	DATE		Second transfusion date
6	DATA_SACCA7	DATE		Third transfusion date
7	EMO_GRUPPO	CHAR(50)	copied from basic data	Blood group
8	EMO_RH	CHAR(50)	copied from basic data	Blood group (Rh)
9	FENOTIPO	CHAR(12)	copied from basic data	Phenotype
10	FILTRATE	CHAR(50)		Unit type
11	HB_CONTROLLO	NUM(5,2)		Hb at check
12	IDENTIFIER	CHAR(15)	copied from basic data	Unique dentificator
13	N_RICH_A	NUM(4)		Total units required (first transfusion)
14	N_RICH_B	NUM(4)		Total units required (second transfusion)
15	N_RICH_C	NUM(4)		Total units required (third transfusion)
16	NATO	DATE	copied from basic data	Birth date
17	NOME	CHAR(25)	copied from basic data	Name
18	Q_RICH_A	NUM(4)		Total amount required (first transfusion)
19	Q_RICH_B	NUM(4)		Total amount required (second transfusion)
20	Q_RICH_C	NUM(4)		Total amount required (third transfusion)
21	TOT_EMAZIE	NUM(4)	Formula 32 page	Total amount required
22	URGENTE	CHAR(1)	No	Emergency

The following list shows the fields in the order of the input mask (the table includes the field description, the database field name and the reference number in the previous table):

Description	***Name***	***Number***
Patient surname	COGNOME	1
Patient name	NOME	17
Birth date	NATO	16
Check date	DATA_CONTROLLO	3
Hb	HB_CONTROLLO	11
Weight	PESO	From last DH
Transfused amount of red blood cells	TOT_EMAZIE	21
Unit type	FILTRATE	10
Transfusion date	DATA_SACCA1	4
Required volume	Q_RICH_A	18
Required units	N_RICH_A	13
Emergency	URGENTE	22
Transfusion date	DATA_SACCA4	6
Required volume	Q_RICH_B	19
Required units	N_RICH_B	14
Transfusion date	DATA_SACCA7	7
Required volume	Q_RICH_C	20
Required units	N_RICH_C	15

Summary File

File containing annual summary data on the patient.

Num	*Name*	*Type*	*Default / Formula*	*Description*
1	ALT_MEDIA	NUM(6,2)	Formula 31 page44	Mean ALT
2	ALTEZ_ULT	NUM(6,2)	copied from DH	Last height
2	ANNO	CHAR(4)	Today year	Summary year
3	COGNOME	CHAR(17)	copied from basic data	Surname
4	COMPLIANCE	NUM(5,1)	Formula 31 page44	Desferal Compliance
5	COMPLICANZE	CHAR(20)	copied from basic data	Complications
6	CONSUMO	NUM(6,1)	Formula 26 page43	Total blood cells used
7	DECR_PERC	NUM(6,2)	Formula 31 page44	% mean fall
8	DESF_TYPE	CHAR(2)		Desferal type
9	ETA	NUM(3)	Formula 24 page43	Age at summary (months)
10	FE_ELIM	NUM(7,2)	Formula 29 page43	Iron excreted
11	FE_ELIM_T	NUM(7,2)	Formula 30 page44	Total iron excreted
12	FE_INTR_T	NUM(7,2)	Formula 30 page44	Total iron in
13	FE_INTROD	NUM(7,2)	Formula 28 page43	Iron In
14	FERRIT_MAX	NUM(5)	From DH	Maximun ferritin value
15	FERRIT_MEDIA	NUM(5)		Mean Ferritin
16	FERRIT_MIN	NUM(5)	From DH	Minimun ferritin value
17	FERRIT_ULT	NUM(5)	copied from DH	Most recently ferritin value
18	HB_MEDIA	NUM(5,1)	Formula 31 page44	Mean hb
19	HB_POST_TIPO	CHAR(1)	copied from DH	Hb post type
20	IDENTIFIER	CHAR(15)	not used	
21	LIC_MEDIO	NUM(6,2)		Mean LIC
22	MOSTDOC__KEY	CHAR(18)	assigned	Unique Identificator
23	NATO	DATE	copied from basic data	Birth date
24	NOME	CHAR(17)	copied from basic data	Name
25	NUM_TRASF	NUM(4)	Formula 25 page43	Total transfusion number
26	PESO_ULT	NUM(6,2)	copied from DH	Last weight
27	POST_MEDIA	NUM(5,1)	Formula 31 page44	Mean post trasfusional hb
28	PRE_MEDIA	NUM(5,1)	Formula 31 page44	Mean pre trasfusional hb
29	SGPT_MEDIA	NUM(5,1)	not used	Mean ALT
30	SPLENECTO	CHAR(1)	copied from DH	Splenectomy(Y/N)
31	STORIA	CHAR(250)		Clinical history
32	STORIA_AUT	CHAR(100)	not used	Clinical history
33	VOLEMIA	NUM(6,2)	not used	Volemia

The following list shows the fields in the order of the input mask (the table includes the field description, the database field name and the reference number in the previous table):

Description	*Name*	*Number*
Patient surname	COGNOME	3
Patienmt name	NOME	24
Birth date	NATO	23
Clinical history	STORIA	31

Sideruria File

File containing the data on the patient's sideruria

Num	*Name*	*Type*	*Default / Formula*	*Description*
1	ALTRE	NUM(6,2)		Other
2	CHELANTE	CHAR(3)	previous value	Desferal / Deferiprone
3	COGNOME	CHAR(17)	copied from basic data	Surname
4	DATA_RACCOLTA	DATE	today	Sampling date
5	DIURESI	NUM(4)		Diuresis
6	DOSE	NUM(5,1)		Dosage
7	DOSE_DIE	NUM(5,1)		Daily dosage
8	HB	NUM(5,1)	Formula 23 page 43	Hb
9	IDENTIFIER	CHAR(15)	copied from basic data	Unique Identificator
10	MEDIA	NUM(6,2)		Mean urinary iron excretion
11	MOSTDOC__KEY	CHAR(18)	calculated	Unique key
12	NATO	DATE	copied from basic data	Birth year
13	NOME	CHAR(17)	copied from basic data	Name
14	PER_CALCOLO	CHAR(1)	yes	To use in calculation
15	SID_CONC	NUM(6,2)		Conc urinary iron excretion
16	SID_MG_KG	NUM(6,2)	Formula 22 page 43	Mg/kg urinary iron excretion
17	SIDERURIE	NUM(6,2)	previous value	Total urinary iron excretion
18	VITC	NUM(6,2)	Copied from DH	Ascorbic acid

The following list shows the fields in the order of the input mask (the table includes the field description, the database field name and the reference number in the previous table):

Description	*Name*	*Number*
Patien surname	COGNOME	3
Patient name	NOME	13
Birth date	NATO	12
Sampling date	DATA_RACCOLTA	4
Chelator name	CHELANTE	2
Chelantor dosage	DOSE	6
Diuresis	DIURESI	5
Conc urinary iron excretion	SID_CONC	15
Total urinary iron excretion	SIDERURIE	17
To use in calculation	PER_CALCOLO	14
Ascorbic acid	VITC	18
Others	ALTRE	1

Deferiprone (L1) File

File containing data on weekly checks on patients treated with L1 therapy

Num	*Name*	*Type*	*Default/Formula*	*Description*
1	CODICE_L1	CHAR(18)	copied from basic data	L1 code
2	COGNOME	CHAR(25)	copied from basic data	Surname
3	CP_CONSEGNATE	NUM(4)		Given tablets number
4	CP_DIE	NUM(3,1)	Copied from last hospitalization	Tablets pro die
5	CP_RIMASTE	NUM(4,1)	Formula 37 page44	Tablets remained
6	DATA_CONSEGNA	DATE	Copied from last hospitalization	Delivery date
7	DATA_CONTR	DATE		Check date
8	DATA_CONTR_SUCC	DATE		Next check date
9	ERITRO_CORR	NUM(6,2)	Formula 34 page 44	Absoluted NRBC
10	ERITRO_PERC	NUM(5,2)		% NRBC
11	FERRITINA	NUM(7,2)		Ferritin
12	GLOBULI_B_CORR	NUM(6,2)	Formula 35 page 44	White cells number
13	HB_CONTR	NUM(6,2)		Haemoglobin at check
14	IDENTIFIER	CHAR(15)	copied from basic data	Patient Id
15	MOSTDOC__KEY	CHAR(18)	assigned	Id
16	NATO	DATE	copied from basic data	Birth date
17	NEUTRO_CORR	NUM(6,2)	Formula 36 page 44	Neutrophils absolut number
18	NEUTRO_PERC	NUM(5,2)		% neutrophils
19	NOME	CHAR(25)	copied from basic data	Name
20	NOTE	CHAR(100)		Note
21	NUCLEATE_TOT	NUM(6,2)		Total nucleated cells
22	PIASTRINE	NUM(6,2)		Platelets
23	RICALCOLO	CHAR(1)		Hb_post last hospitalization recalculation
24	SGPT	NUM(6,1)	Copied from last hospitalization	Alt
25	SIDERURIA	NUM(4)	Copied from last urinary iron excretion	Urinary iron excretion

The following list shows the fields in the order of the input mask (the table includes the field description, the database field name and the reference number in the previous table):

Description	*Name*	*Number*
Surname	COGNOME	2
Name	NOME	19
Birth date	NATO	16
Check date	DATA_CONTR	7
Hb at check	HB CONTR	13
Total nucleated	NUCLEATE TOT	21
% Neutrophils	NEUTRO_PERC	18
Neutrophils absolut number	NEUTRO CORR	17
% NRBC	ERITRO PERC	10
Platelets	PIASTRINE	22
Tablets pro die	CP DIE	4
Tablets remained	CP RIMASTE	5
Tablets given	CP CONSEGNATE	3
Delivery date	DATA CONSEGNA	6
Next check date	DATA CONTR SUCC	8
Comments	NOTE	20
Hb_post recalculation	RICALCOLO	23
Ferritin	FERRITINA	11
Alt	SGPT	24
Urinary iron excretion	SIDERURIA	25

Instrumental tests file

File containing data on instrumental tests and specialist examinations

Num	*Name*	*Type*	*Default / Formula*	*Description*
1	COGNOME	CHAR(25)	assigned	Surname
2	DATA_CONTR	CHAR(10)		Next check date (in letters)
3	DATA_CONTR1	DATE	data attuale	Next check date
4	DATA_ESAME	DATE	data attuale	Examination date
5	DATA_INGRESSO	DATE	data ultimo ricovero	Hospitalization date
6	ESITO	CHAR(40)		Result
7	MOSTDOC__KEY	CHAR(18)	assigned	Unique Id
8	NATO	DATE	assigned	Birth date
9	NOME	CHAR(25)	assigned	Name
10	NOTE	CHAR(250)		Comments
11	TIPO_ESAME	CHAR(50)		Examination type

The following list shows the fields in the order of the input mask (the table includes the field description, the database field name and the reference number in the previous table):

Description	*Name*	*Number*
Surname	COGNOME	1
Name	NOME	9
Birth Date	NATO	8
Program	PROG_STRU	In basic data
Hospitalization date	DATA_INGRESSO	5
Examination date	DATA_ESAME	4
Examination type	TIPO_ESAME	11
Result	ESITO	6
Comments	NOTE	10
Next check date	DATA_CONTR1	3
Check description	DATA_CONTR	2

Cardiology file

File containing data on cardiological examinations

Num	*Name*	*Type*	*Default / Formula*	*Description*
1	ALDOSTERONE	NUM(3)		Aldosterone
2	ALTRO	CHAR(50)		Other
2	ALTROD	NUM(5,2)		Other
3	ANP	NUM(3)		Anp
4	CLASSE_NYHA	CHAR(50)		Nyha class
5	CMV	NUM(3)		Cmv
6	COGNOME	CHAR(25)	copied from basic data	Surname
7	COMMENTO	CHAR(250)		Comments
8	COX_A	NUM(3)		Coxsackie A
9	COX_B	NUM(3)		Coxsackie B
10	DATA_VISITA	DATE	today	Visit date
11	DEFIBRI	CHAR(50)		Defibrillation
12	DIAGNOSI	CHAR(50)		Diagnosis
13	DIGOSSINEMIA	NUM(4)		Digossinemia
14	ECG	CHAR(50)		Ecg
15	ECHO	NUM(3)		Echo
16	ECO_DIAM	NUM(6,2)		Dyameter
17	ECO_FE	NUM(5,2)		Fe
18	EDEMI	CHAR(2)		Edemas
19	EPATOMEGA	NUM(6,2)		Liver
20	EPATOMEGA1	CHAR(50)		Hepatomegaly
21	ERGO	CHAR(20)		Ergospirometry
22	FA	CHAR(1)		FA
23	FREQ_RIP	NUM(4)		Heart rate
24	FUMO	CHAR(1)		Smoker
25	HBS	CHAR(1)		Hbs
26	HCV	CHAR(1)		Hcv
27	HIV	CHAR(1)		Hiv
28	HOLTER	CHAR(50)		Holter
29	IDENTIFIER	CHAR(15)	copied from basic data	Unique Identificator
30	INDICE_CT	NUM(5)		Ct Index
31	INF_A	NUM(3)		Influenzae A
32	INF_B	NUM(3)		influenzae B
33	MEDICO	CHAR(20)		Physician
34	MOSTDOC__KEY	CHAR(18)	assigned	Unique Identificator
35	MOTIVO	CHAR(50)		Visit cause
36	NATO	DATE	copied from basic data	Birth date
37	NOME	CHAR(25)	copied from basic data	Name
38	PM_MOTIVO	CHAR(10)		PM cause
39	PM_TIPO	CHAR(10)		PM type
40	POTENZIALI	CHAR(1)		Potentials
41	PRA	NUM(3)		Pra
42	PRESS_MAX	CHAR(7)		Max pressure
43	PRESS_MIN	CHAR(7)		Min Pressure
44	QT_CORRETTO	NUM(4)		Corrected Potentials
45	QT_MISURATO	NUM(4)		Mesured Potentials
46	QT_SEC	NUM(3)		Qt_sec
47	REFLUSSO	CHAR(50)		Reflusso
48	RITMO	CHAR(2)		Rhytm
49	STASI	CHAR(20)		Stasi
50	T3	NUM(4)		T3
51	T4	NUM(4)		T4
52	TPHA	NUM(3)		Tpha
53	TPSV	CHAR(1)		TPSV
54	TSH	NUM(4)		TSH
55	TV	CHAR(1)		TV
56	VDX	CHAR(1)		Vdx

The following list shows the fields in the order of the input mask (the table includes the field description, the database field name and the reference number in the previous table):

Description	***Name***	***Number***
Surname	COGNOME	6
Name	NOME	37
Birth Date	NATO	36
Program	PROG_CARDIO	In basic data
Examination Date	DATA_VISITA	10
Physician	MEDICO	33
Cause	MOTIVO	35
Dyastolic Pressure	PRESS_MIN	43
Systolic Pressure	PRESS_MAX	42
Frequency	FREQ_RIP	23
Epatomegaly	EPATOMEGA1	20
Pulmonary stasis	STASI	49
Edemas	EDEMI	18
Hepato jugular reflux	REFLUSSO	47
Rhytm	RITMO	48
NYHA class	CLASSE_NYHA	4
E.K.G.	ECG	14
Sec	QT_SEC	46
FE	ECO_FE	17
DTD	ECO_DIAM	16
VDX	VDX	56
Holter	HOLTER	28
Ergo Watt	ERGO	21
Diagnosis	DIAGNOSI	12
Comments	COMMENTO	7
QT Mesured	QT_MISURATO	45
QT Corrected	QT_CORRETTO	44
Pot Tard	POTENZIALI	40
Smoke	FUMO	24
Aldosterone	ALDOSTERONE	1
ANP	ANP	3
CMV	CMV	5
TPHA	TPHA	52
Coxsackie A	COX_A	8
Coxsackie B	COX_B	9
Influenzae A	INF_A	31
Influenzae B	INF_B	32
Liver	EPATOMEGA	19

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